

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2016
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NAME OF PROVIDER OR SUPPLIER
LIFE CARE CENTER OF KONA

STREET ADDRESS, CITY, STATE, ZIP CODE
**78-6957 KAMEHAMEHA III ROAD
KAILUA KONA, HI 96740**

2016 JUN 27 P 3:37

STATE OF HAWAII
DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	11-94.1 Initial Comments A licensure survey was conducted from 5/31/16 through 6/3/16. The census at the time of the survey was 85 residents.	4 000	THE PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTIONS DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF THE DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISION OF FEDERAL AND STATE LAW, FOR THE PURPOSE OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 7305 OF THE STATE OPERATIONS MANUAL.	
4 105	11-94.1-22(g) Medical record system (g) All entries in a resident's record shall be: (1) Accurate and complete; (2) Legible and typed or written in black or blue ink; (3) Dated; (4) Authenticated by signature and title of the individual making the entry; and (5) Written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical doctor. This Statute is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to keep resident medical records accurate and complete for 2 of 23 residents sampled in the stage 2 sample. Findings include: [REDACTED]	4 105	CORRECTIVE ACTION FOR ALLEGED DEFICIENT PRACTICE: On 6/23/16 the Director of Nursing provided education to licensed nurses responsible for the missing documentation in the Medication Administration Record (MAR) for the identified resident. Beginning 6/23/16 the Director of Nursing educated licensed nurses related to assuring that appropriate information is received from the [REDACTED] facility that includes the completion of the [REDACTED] communication tool by the [REDACTED] facility, the education also included the licensed nurses responsibility in completion of their sections of the [REDACTED] communication tool, entering dry weight in Sofcare	7/1/16

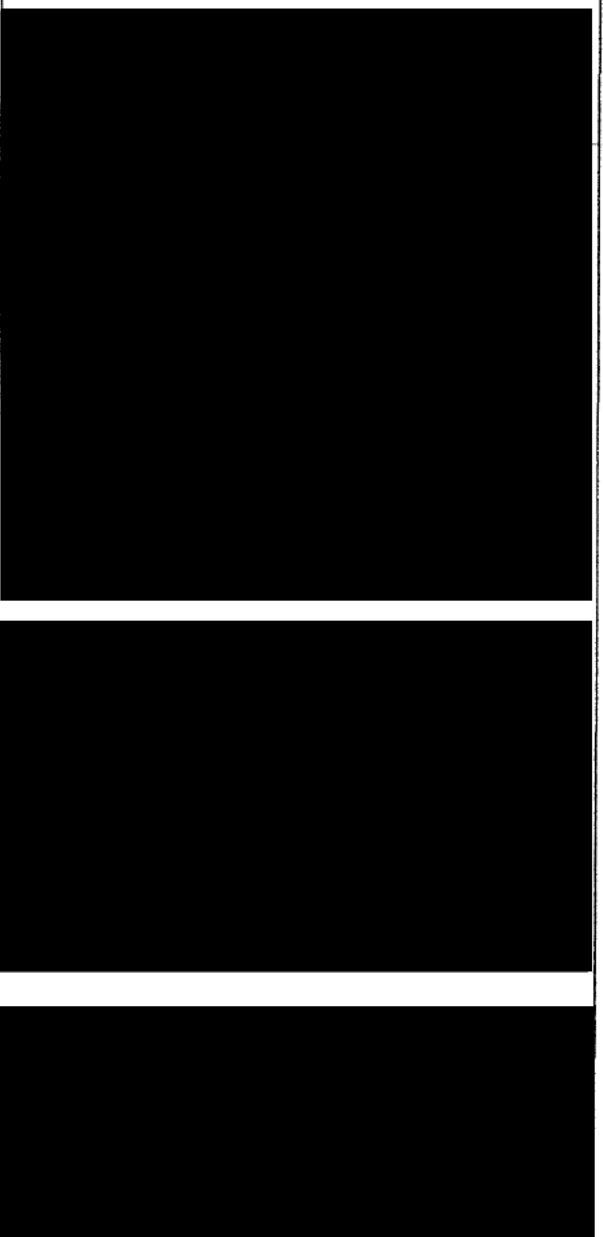
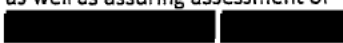










Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
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(X6) DATE
6/23/16

STATE FORM 6899 HGN 11 If continuation sheet 1 of 14

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4 105	Continued From page 1 	4 105	<p>as well as assuring assessment of  documented in the MAR before and after  and weight prior to and after  and the importance of obtaining labs/consults as ordered.</p> <p>Beginning 6/23/16 the Director of Nursing/designee educated licensed nurses and Certified Nursing Assistants related to proper documentation of resident fluid intake, this education included fluid intake documentation on the MAR for residents on fluid restriction. On 6/21/16 the Executive Director and met with the  facility via telephone to review the  communication tool and assure that the  facility staff are completing appropriately and returning with the resident upon treatment completion. Also will ask  center to provide lab results and  notes.</p> <p>IDENTIFYING OTHERS AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: On 6/23/16 the Director of Nursing completed a 100% audit of all resident records that receiving  nutritional supplementation. Any identified issues were addressed with appropriate corrective action to licensed nurses.</p> <p>On 6/23/16 the Director of Nursing completed 100% audit of residents receiving  to assure appropriate documentation was included in the medical record from and to the  and for fluid intake. Any identified areas of concern were addressed at the time of discovery.</p>	

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4 105	Continued From page 2 [REDACTED]	4 105	MEASURES/SYSTEMIC CHANGES: Beginning 6/23/16 the Director of Nursing provided education to all licensed nurses related to appropriate documentation in the MAR for residents receiving nutritional supplementation.	
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observation and interview, the facility did not promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. (Resident #11) Findings include: [REDACTED]	4 115	Beginning 6/23/16 the off-going nurse will review the MAR with the on-coming nurse for any missed documentation of nutritional supplementation. Beginning 6/23/16 the Neighborhood Nurse Managers will complete a daily audit of the MAR for residents receiving nutritional supplementation. Any issues noted will be reported to the Director of Nursing and addressed immediately with the responsible licensed Nurse. Neighborhood Nurse Managers complete daily [REDACTED] audit of resident medical record to assure that documentation is completed appropriately by nursing home staff and [REDACTED] staff and that it is returned from the [REDACTED] when resident returns to the nursing home. This audit will include the completion of the [REDACTED] communication tool by the [REDACTED] facility, licensed nurses completion of their sections of the [REDACTED] communication tool, entering dry weight in Sofcare as well as assuring assessment of [REDACTED] [REDACTED] documented in the MAR before and after [REDACTED] and weight prior to and after [REDACTED] and obtaining labs/consults as ordered.	7/1/16

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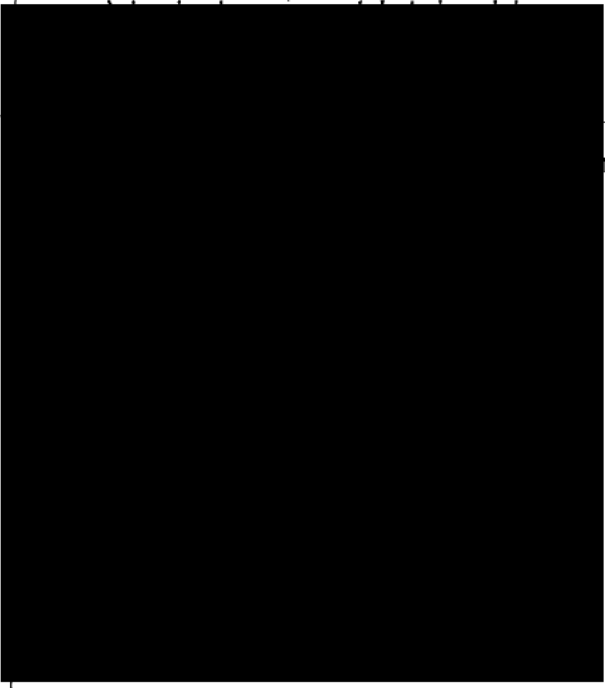
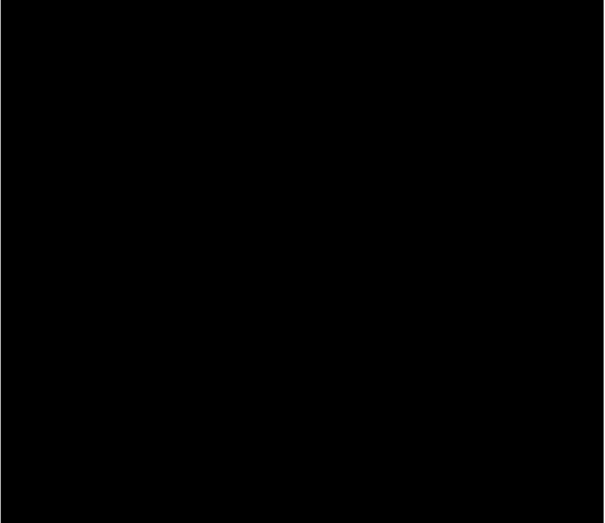
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4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to:	4 136	Neighborhood Nurse Managers complete daily audit of resident fluid intake for resident [REDACTED] to assure that C.N.A.'s and licensed staff are documenting per protocol. This audit will continue for 90 days or until sustained compliance is achieved.	7/1/16
	<p>(1) Respiratory care including ventilator use;</p> <p>(2) Dialysis;</p> <p>(3) Skin care and prevention of skin breakdown;</p> <p>(4) Nutrition and hydration;</p> <p>(5) Fall prevention;</p> <p>(6) Use of restraints;</p> <p>(7) Communication; and</p> <p>(8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth.</p> <p>This Statute is not met as evidenced by: Based on observation, record review and interview with staff members, the facility failed to ensure care and services to attain and maintain the highest practicable physical well-being for 1 (Resident #15) of 1 residents reviewed for [REDACTED] services provided by an outside entity.</p> <p>Finding includes:</p> <p>[REDACTED]</p>		<p>The Director of Nursing will complete weekly audit of dialysis communication documentation and fluid intake documentation for residents [REDACTED] to assure thorough completion. This audit will continue for 90 days or until sustained compliance is achieved.</p> <p>If areas of concern are noted, the Director of Nursing will complete one to one inservice education to licensed nurse and/or C.N.A. and will contact the [REDACTED] management staff if necessary.</p> <p>MONITORING PERFORMANCE:</p> <p>The Director of Nursing will provide documentation audits to the Executive Director weekly. Any trends or patterns noted related to completion of the [REDACTED] communication tool, fluid intake or missing MAR documentation of nutritional supplementation will be logged as a problem by the QAPI Committee and corrective action will be taken.</p> <p>Any trends or patterns noted related to missing MAR documentation of nutritional supplementation will be logged as a problem by the QAPI Committee and corrective action will be taken.</p>	

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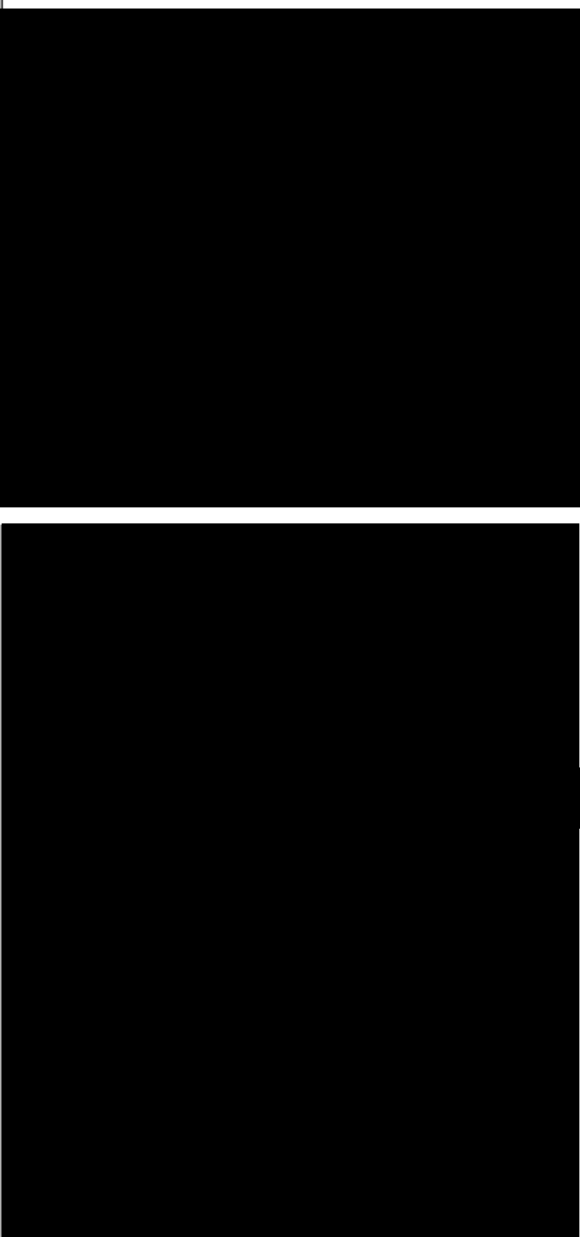



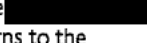
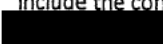
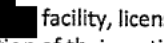


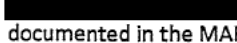


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4 136	Continued From page 4 	4 136	CORRECTIVE ACTION FOR RESIDENT AFFECTED BY ALLEGED DEFICIENT PRACTICE: On 6/21/16 the Executive Director contacted the [redacted] facility to obtain records that include lab results, physician progress notes, and treatment notes.	7/1/16
			Beginning 6/23/16 the Director of Nursing educated licensed nurses related to assuring that appropriate information is received from the [redacted] facility that includes the completion of the [redacted] communication tool by the [redacted] facility, the education also included the licensed nurses responsibility in completion of their sections of the [redacted] communication tool, entering dry weight in Sofcare as well as assuring assessment of [redacted] documented in the MAR before and after [redacted] and weight prior to and after [redacted] and the importance of obtaining labs/consults as ordered. Beginning 6/23/16 the Director of Nursing/designee educated licensed nurses and Certified Nursing Assistants related to proper documentation of resident fluid intake, this education included fluid intake documentation on the MAR for residents on fluid restriction. On 6/21/16 the Executive Director met with the [redacted] facility via telephone to review the [redacted] communication tool and assure that the [redacted] facility staff are completing appropriately and returning with the resident upon treatment completion. Also will ask [redacted] to provide lab results and [redacted] notes.	

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4 136	Continued From page 5 	4 136	<p>On 6/23/16 the Registered Dietitian completed education to the residents responsible party related to the residents fluid restrictions and dietary orders.</p> <p>IDENTIFYING OTHER RESIDENTS AFFECTED BY ALLEGED DEFICIENT PRACTICE:</p> <p>On 6/23/16 the Director of Nursing completed 100% audit of residents  to assure appropriate documentation was included in the medical record from and to the  and for fluid intake. Any identified areas of concern were addressed at the time of discovery.</p> <p>MEASURES/SYSTEMIC CHANGES:</p> <p>Neighborhood Nurse Managers complete daily (dialysis day) audit of resident medical record to assure that documentation is completed appropriately by nursing home staff and  staff and that it is returned from the  when resident returns to the nursing home. This audit will include the completion of the  communication tool by the  facility, licensed nurses completion of their sections of the  communication tool, entering dry weight in Sofcare as well as assuring assessment of   documented in the MAR before and after  and weight prior to and after  and obtaining labs/consults as ordered.</p>	

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4 136	Continued From page 6 [REDACTED]	4 136	<p>Neighborhood Nurse Managers complete daily audit of resident fluid intake for residents receiving [REDACTED] to assure that C.N.A.'s and licensed staff are documenting per protocol. This audit will continue for 90 days or until sustained compliance is achieved.</p> <p>The Director of Nursing will complete weekly audit of [REDACTED] communication documentation and fluid intake documentation for residents [REDACTED] to assure thorough completion. This audit will continue for 90 days or until sustained compliance is achieved.</p> <p>If areas of concern are noted, the Director of Nursing will complete one to one inservice education to licensed nurse and/or C.N.A. and will contact the [REDACTED] management staff if necessary.</p> <p>MONITORING PERFORMANCE: The Director of Nursing will provide documentation audits to the Executive Director weekly.</p> <p>Any trends or patterns noted related to completion of the [REDACTED] communication tool and fluid intake will be logged as a problem by the QAPI Committee and corrective action will be taken.</p>	

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4 136	Continued From page 7 	4 136	CORRECTIVE ACTION FOR AREA AFFECTED BY ALLEGED DEFICIENT PRACTICE: On 5/31/16 all expired sandwiches were removed from the refrigerator on the Reflections neighborhood.	
4 159	 11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation and interview with staff members, the facility failed to ensure food was stored under sanitary conditions. Findings include: On 6/1/16 at 10:20 A.M. observed	4 159	IDENTIFYING OTHER AREAS AFFECTED BY THE ALLEGED DEFICIENT PRACTICE: On 5/31/16 the Dietary Manager and the Registered Dietitian audited every storage area on all neighborhoods and kitchen no other expired food items were found. MEASURES/SYSTEMIC CHANGES: All food items will be labeled and dated to include the type of food item and the date opened. All food items stored in the refrigerators on the neighborhoods will have the date prepared/opened and the expiration date that will be 72 hours later, at which time it will be discarded. On 6/15/16 the Executive Director provided education to dietary staff that included policy review about storage, labeling and dating food.	7/1/16

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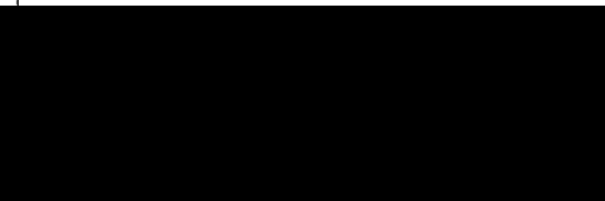







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4 159	Continued From page 8 half-sandwiches in plastic wrap placed on a tray in the refrigerator. The observation found five of the sandwiches with dates handwritten on the wrapping of 5/17/16, 5/30/16 and 5/31/16 and two sandwiches with dates of 5/23/16 and 5/27/16 written on it. Concurrent observation with the Registered Dietitian (RD) confirmed the dates on the sandwiches note the date the sandwiches were made and the date for disposal. Concurrent observation and interview with the Food Service Manager (FSM) at 10:25 A.M. confirmed the sandwiches should have been discarded and threw the sandwiches out.	4 159	Beginning 6/22/16 the Dietary Manager/designee will complete a daily audit of food storage areas including the refrigerators on the neighborhoods to assure all items are properly labeled and dated and that there are no expired food items. Beginning 6/23/16 the RD and/or the Executive Director will complete weekly food storage area audits to assure all items are properly labeled and dated and that there are no expired food items.	
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on record review and interview with facility staff, the facility failed to develop a comprehensive care plan to include the use of [REDACTED] for 1 (Resident #167) of 5 residents included in the medication review. Findings include: [REDACTED]	4 174	The results of the food storage audits will be reviewed by the Executive Director, any issues noted will be addressed and corrective action will be reviewed by the QAPI committee. CORRECTIVE ACTION FOR RESIDENT AFFECTED BY ALLEGED DEFICIENT PRACTICE: The care plan for resident #167 was updated on 6/3/16 by the MDS Coordinator for the [REDACTED] medication that is ordered. IDENTIFYING OTHER RESIDENTS AFFECTED BY ALLEGED DEFICIENT PRACTICE: Beginning 6/20/16 a 100% audit of residents with orders for [REDACTED] medications was completed by the MDS Coordinator to assure that all had appropriate care plans in place.	7/1/16

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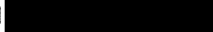



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4 174	Continued From page 9  	4 174	MEASURES/SYSTEMIC CHANGES: Care plans for use of   medications will be completed at the time that the Physician's order is received. On 6/23/16 the DON provided education to all nurses who receive Physician orders to assure that care plans are created at the time they receive the order for   The Neighborhood Nurse Managers review all new Physician orders daily during grand rounds, at this time the Nurse Manager will assure that the care plans are completed. The DON/designee will complete weekly audits for 30 days or until sustained compliance is achieved of Physician orders for   medications	
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observations, staff interview, and policy review, the facility did not ensure expired medications were discarded and not available for use. Findings include: 	4 197	to assure that care plans are completed. The results of these audits will be provided to the Executive Director. MONITORING PERFORMANCE: Any issues noted related to care plans for anti-depressant and/or anti-psychotic medications will be addressed by the Executive Director and corrective action will be reviewed by the QAPI Committee. CORRECTIVE ACTION FOR IDENTIFIED AREA OF ALLEGED DEFICIENT PRACTICE: The eye drops and insulin identified in the statement of deficiency were discarded when discovered.	7/1/16

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2016
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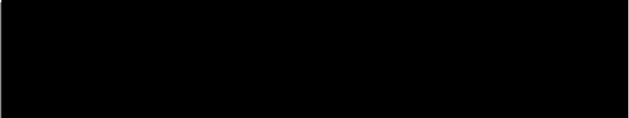

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KONA	STREET ADDRESS, CITY, STATE, ZIP CODE 78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740
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4 197	Continued From page 10 	4 197	<p>IDENTIFYING OTHER AREAS AFFECTED BY ALLEGED DEFICIENT PRACTICE: On 6/3/16 the Director of Nursing/designee inspected all medication storage areas for expired medications . Any expired medications discovered were discarded.</p> <p>MEASURES/SYSTEMIC CHANGES: On 6/23/16 the Director of Nursing provided education to all licensed nurses about inspecting medications for expiration date prior to use and included assuring that expired  need to be discarded. Beginning 6/22/16 the Neighborhood Nurse Managers will audit all medication storage areas for their assigned neighborhoods weekly for 30 days to assure that expired medications  have been discarded. The consultant Pharmacist will audit all medication storage areas monthly for 90 days to assure that expired medications including  have been discarded. Beginning 6/22/16 the Director of Nursing will complete weekly random audits for 30 days of medication storage areas to assure that expired medications including  have been discarded.</p> <p>MONITORING PERFORMANCE: The results of the weekly medication storage area audits will be reviewed by the Executive Director, any issues noted will be addressed and corrective action will be reviewed by the QAPI committee.</p>	

Hawaii Dept. of Health, Office of Health Care Assurance

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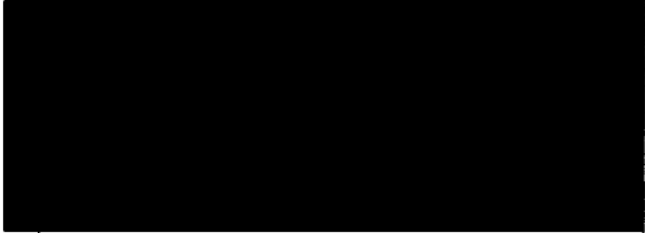
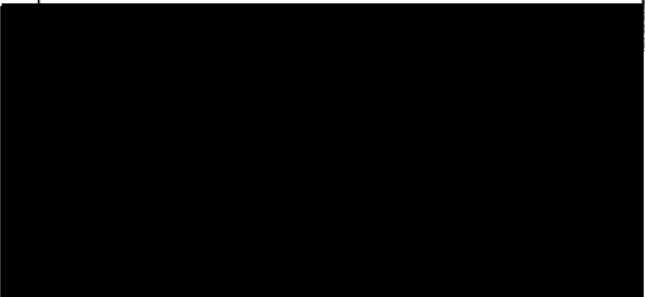
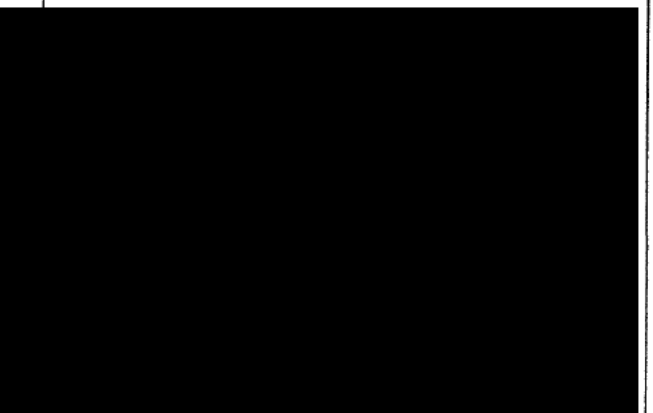
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KONA	STREET ADDRESS, CITY, STATE, ZIP CODE 78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740
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4 197	Continued From page 11 	4 197	CORRECTIVE ACTION FOR AREA AFFECTED BY ALLEGED DEFICIENT PRACTICE: On 6/3/16 the Director of Nursing provided education to the 2 nurses about proper hand washing and glove use and about infection control practices when handling medications.	
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observations, staff interviews, and policy review, the facility did not maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Findings include: 	4 203	IDENTIFYING OTHER AREAS AFFECTED BY ALLEGED DEFICIENT PRACTICE: All licensed nursing staff are observed by nursing administration with proper hand washing and use of gloves as of 6/23/16. MEASURES/SYSTEMIC CHANGES: On 6/23/16 the Director of Nursing provided education to all licensed nurses about proper glove use and hand washing and handling of medications. Beginning 6/23/16 the Director of Nursing/designee will complete discriminate observation 3 times a week for 3 months, of licensed nursing staff completing tasks during medication administration to assure that proper glove use, hand washing and handling of medications techniques are followed. Any issues noted will be immediately addressed. MONITORING PERFORMANCE: The results of the discriminate observations will be reviewed by the Executive Director, any issues noted will be addressed and corrective action will be reviewed by the QAPI committee.	7/1/16

Hawaii Dept. of Health, Office of Health Care Assurance

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4 203	Continued From page 12 	4 203		
				
				
				

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4 203	Continued From page 13 [REDACTED]	4 203		