Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING: _____ B. WING _____ RECEIVED	08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 2016 SEP 26 P 3:26 HILO, HI 96720

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4 000	11-94.1 Initial Comments A relicensure survey was conducted by the Hawaii State Survey Agency from August 10 to 12, 2016. The census at the time of entrance was 86 residents.	4 000	Submission of this response and plan of correction is not a legal admission that a deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employees, agents or other individuals who draft or may be discussed in the response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute admission on agreement of any kind by the facility of the truth of any acts alleged of the correction of any conclusions set forth in the allegation by the survey team. The Plan of Correction shall constitute the facility's credible allegations of compliance.	
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: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in according with the comprehensive assessment and plan of care. Findings include:	4 136	**4 136/11-94. 1-30 Resident Care** **Resident Specific:** This facility will ensure that all residents' complaints of pain are reported to the LN in a timely and efficient manner. DON has re-educated nursing staff regarding pain management on 8/17/16.	

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/23/16.

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4 136	Continued From page 1	4 136		

Identifying Other Residents:

All residents were reviewed through a 100% audit of their most recent pain assessment, diagnosis, and current medication regimen with all licensed nurses to determine if any residents were complaining of increased and or unmanageable pain and that those complaints to non-licensed and or non-nursing staff had been relayed to Licensed nurses for complete assessment and continued monitoring.

All residents with Pressure Ulcer(s) have the potential to be affected.

Systemic changes ensure that deficient practice does not recur include:

1) A pain management focused meeting will be held daily during Stand-Up and Grand Rounds. The "Stop and Watch" tool an Interact form/tool will be completed by CNA/LN in EMR system and by ancillary staff on paper form any time there is a change or concern related to a resident. This tool will be reviewed every shift by Licensed Nurse and by Unit Manager in clinical meeting/ground rounds each morning. DON has re-educated nursing staff regarding pain

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4 136	Continued From page 2	4 136	management and utilization of "Stop and Watch" tool on 8/17/16. 2) Staff re-education regarding pain management and assessment completed on 9/21/16 by Staff Development Coordinator or designee. 3) On 8/11/16, the Unit Manager immediately educated CNA on reviewing and following "Kardex/Care guide" on EMR to ensure proper off-loading is practiced. On 8/17/16, the DON provided training/in-service to all Unit managers and licensed nurses with emphasis on CNA oversight during rounding. 4) The DON/Designee will review skin assessment records, care plans, and care guides at weekly Skin and Weight meeting to ensure skin assessments and treatments are completed as scheduled, interventions are followed by CNA's. 5) CNA's will report to charge nurse when off-loading devices has been placed. LNs will visualize placement to ensure that off-loading devices have been placed appropriately. 6) Staff re-education on appropriate treatment, assessment and interventions for pressure ulcers	

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4 136	Continued From page 3 An interview was done with a Licensed Nurse, LN, on 8/12/2016 at 4:00 P.M. Surveyor asked LN, "What does "E" mean to you?" The LN explained that it meant the pain medication was effective. Surveyor asked, "How do you measure effectiveness?" LN was not able to explain how to measure effectiveness.	4 136	completed on 9/21/16 by Staff Development Director or designee. **System Monitoring (QAPI) to ensure deficient practice will not recur:** DON or designee will also conduct a weekly pain managment audit x 8 weeks to validate compliance. The DON or designee will provide monthly summary of findings to the QAPI committee every month for three months and as needed thereafter to ensure compliance. DON or designee will also conduct an audit 2-3 x per week for 8 weeks and then 3x a month for 2 months to validate placement of off-loading devices. The DON or designee will provide monthly summary of findings to the QAPI committee every month for three months and as needed thereafter to ensure compliance. **Responsible: Director of Nursing or designee** **Compliance date:**	**9/23/16**
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	4 159	**<u>4 159/ 11-94. 1-41(a) Storage and Handling of Food</u>** **Resident Specific:** No resident was specifically identified as having been affected. The refrigerator was immediately checked for outdated beverages. Expired	

items were removed and discarded. Dietary department rearranged shelves and labeled by juice type and liquid consistency with boxed beverages placed on lower shelves so dates are easier to read. Nursing department checks at midnight of expired date. Dietary to do additional check before 6:00 AM next morning. This duty has been added to Dietary checklist. Expired items were immediately removed and discarded.

Identifying Other Residents:

All residents have the potential to be affected. Corrective actions apply to all residents.

Systemic changes ensure that deficient practice does not recur include:

1) Nursing department or designee will check for and discard expired items during night shift.
2) Dietary department will do an additional check before 6 AM. The Registered Dietician immediately provided in-service/education to kitchen staff on 8/11/16. DON also educated Nursing department on 8/11/16 with regards to food/beverage storage procedures.
3) Staff re-education regarding food/beverage storage procedures

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4 159	Continued From page 4 proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by:	4 159	completed on 9/21/16 by the Staff Development Coordinator or designee. **System Monitoring (QAPI) to ensure deficient practice will not recur:** The FSM or designee will audit daily x 2 weeks, then 2-3 times per week for 2 weeks and monthly x 2 months. The FSM or designee will provide monthly summary of findings and any corrective action implemented to the QAPI committee every month for three months and as needed thereafter to ensure compliance. **Responsible: Food Service Manager or designee**	
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 observation, record review and interview with staff members, the facility failed to ensure the development of a comprehensive care plan for 1 of 18 sampled residents of the 23 residents who were included in the Stage 2 review. Findings include:	4 174	**Compliance date:** **9/23/16** **<u>4 174 11-94. 1-43 (b) Interdisciplinary care process</u>** **Compliance date:** **9/23/16** **Resident Specific:** **Identifying Other Residents:**	

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4 174	Continued From page 5	4 174	Residents with a change in Level of Care (LOC) have the potential to be affected. An audit of current resident with diagnosis was conducted on 8/12/16 by Unit Managers, Social Services, and MDS Coordinator to determine if care plans reflect the residents needs based on the most recent comprehensive assessment and MD progress notes and orders. Any other incomplete care plans identified were updated at the time by the Unit Managers. **Systemic changes ensure that deficient practice does not recur include:** 1) The DON re-educated the IDT team on 8/12/2016 to the requirement that a facility must develop a comprehensive care plan for each resident based on the care needs identified in the Comprehensive assessment, MD progress notes /orders as well as the IDT ongoing review process. 2) The Medical Records Director will inform IDT of any progress notes written in paper form on a daily basis. 3) Unit Managers (UM) will review MD notes and other documentation to identify residents with a change in LOC. Resident Care plan will be	
4 249	11-94.1-65(b)(2) Construction requirements (b) The facility shall be fully accessible to, and functional for, physically disabled residents, personnel, and the public. (2) Temperature and humidity shall be maintained within a normal comfort range;	4 249		

reviewed and updated to assure care plan accurately reflects current care goals and interventions.

4) Staff re-education regarding proper care plan development completed on 9/21/16 by Staff Development Coordinator or designee.

System Monitoring (QAPI) to ensure deficient practice will not recur:

DON or designee will also conduct a weekly audit x 8 weeks to validate compliance. The DON or designee will provide monthly summary of findings to the QAPI committee every month for three months and as needed thereafter to ensure compliance.

Responsible: Director of Nursing or designee

Compliance date: **9/23/16**

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4 249	Continued From page 6 This Statute is not met as evidenced by: Based on observations, interviews, and record reviews, the facility did not provide comfortable temperature levels for 3 residents interviewed in the Stage 1 sample. Findings include:	4 249	**4 249/ 11-94. 1-65 (b)(2) Construction requirements** **Resident Specific:** Room venting will be evaluated by maintenance to ensure room air conditioning is at a comfortable level for resident. **Identifying Other Residents:** All Residents with have the potential to be affected. Rooms will be tested for appropriate temperature. Residents able to respond will be asked if the room is at a comfortable temperature. If any resident requests a temperature adjustment warmer or cooler, the maintenance department will evaluate venting to ensure proper flow of air conditioning into the room to meet the residents' needs. **Systemic changes ensure that deficient practice does not reoccur include:** 1) Maintenance Director or designee will randomly select 5 rooms per	

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4 249	Continued From page 7	4 249	week to ensure that the temperature is meeting the 71-81 degrees F. requirement. 2) Department managers will ask each resident weekly if they are comfortable with their room temperature. Any concern about room temperature will be placed on the maintenance log for evaluation and correction. 3) Staff re-education regarding proper temperature and comfort in rooms completed on 9/21/16 by Staff Development Coordinator or designee. **System Monitoring (QAPI) to ensure deficient practice will not recur:** Summary report by Maintenance Director of room temp checks and maintenance log regarding issues surrounding room temp/comfort levels will be reviewed at monthly QAPI meeting for 3 months and as needed thereafter to ensure compliance. **Responsible: Maintenance Director or designee** **Compliance date:**	**9/23/16**