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
	125029	A. BUILDING: _____ B. WING _____	10/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMUEL MAHELONA MEMORIAL HOSPITAL	4800 KAWAIHAU ROAD KAPAA, HI 96746

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4 000	11-94.1 Initial Comments A state re-licensure survey was conducted from 10/4 - 10/7/16. At the time of entrance, the resident census was 48.	4 000		
4 088	11-94.1-16(a) Governing body and management (a) Each facility shall have an organized governing body, or designated persons functioning as the governing body, that has overall responsibility for the conduct of all activities. The facility shall maintain methods of administrative management that assure that the requirements of this section are met. This Statute is not met as evidenced by: Based on observation, record review, interviews and review of the facility's policies and procedures, 1) the facility failed to ensure it is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This includes having an organized governing body, or designated persons functioning as the governing body, that has overall responsibility for the conduct of all activities. The facility shall maintain methods of administrative management that assure that the requirements of this section are met; and 2) Based on observations, record review, interviews and review of facility policies, the facility failed to maintain a quality assessment and assurance (QA&A) committee consisting of a physician designated by the facility and demonstrating active participation in the facility's QA&A program. In addition, the QA&A committee did not have a quality assurance program that showed specific standards for quality of care and outcomes, nor have documentation to identify and show the study and improvement of	4 088		

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO Kauai Region | 11/28/16

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4 088	Continued From page 1 processes to better resident care services and outcomes, or to prevent/decrease problems identified with respect to which quality assessment and assurance activities have been necessary to correct identified quality deficiencies. Finding includes:	4 088	4 088 11-94.1-16(a) Governing body and management; Finding #1 Reallocated resources to provide resident focused care: • Nursing Home Administrator's (NHA) job description revised 10/01/16 to focus completely in Long Term Care (LTC); other responsibilities have been assigned to other managers • Current LTC Medical Director resigned effective 1-2-17; replacement being pursued. Administration reiterated with current director his contractual duties and responsibilities. Those duties and responsibilities will be monitored by NHA with any failure to comply reported to CEO • Regional Chief Quality Officer (RCQO) will ensure consistent quality assurance monitoring to identify of any issues needing improvement 4 088 11-94.1-16(a) Governing body and management; Finding #2 RCQO started 08/18/16 Review of data revealed the following: • Annual PPDs were completed • Fit Testing was completed for all clinical employees • Employee Flu Vaccination Campaign for 2016-2017 season scheduled The following needs were identified: • Implementation of the 2017 Hospital Performance Improvement Plan • Interdisciplinary Falls Prevention Task Force • Electronic Event Report Form (ERF) Tracking system to ensure timely response and closure • Regularly scheduled Hospital Performance Improvement Committee (HPIC) meetings	11/03/16 ongoing 07/30/16 09/30/16 10/01/16 10/18/16

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4 088	Continued From page 2	4 088	4 088 11-94.1-16(a) Governing body and management; Finding #2 (continued) • Anti-psychotropic Medication Committee (LTC MD, Social Services (SS), Resident Assessment Instrument (RAI) Coordinator, LTC Nursing Management, and Pharmacist) to meet monthly	10/14/16
			Actions taken to ensure Quality: • HPIC Meeting scheduled to meet monthly - LTC Medical Director attended	10/14/16
			• Falls Prevention Task Force initiated - Findings/ recommendations to be reported to HPIC as standing agenda item	10/18/16
			• Resident Care Assessment will be conducted on resident falls with major injury	
			• Anti-Psychotropic medication trends/ patterns will be reported to HPIC as a standing agenda item	11/15/16
			• LTC Nursing Management will review and report the following to HPIC monthly: - Identified trends (including continued use of medications for unresolved pain) - Residents brought to Emergency Department (ED) for any reason	11/15/16
			• Interim Director of Nursing (DON) working with staff to ensure consistency of care givers	11/18/16
			• In process of replacing LTC Medical Director who rendered his resignation effective 01/02/2017	
			• Interim DON will monitor staff completion of assigned education	
			• Chief Nurse Executive (CNE) will monitor position control for staffing	
4 089	11-94.1-16(b) Governing body and management (b) The facility shall ensure that: (1) Staff sufficient in number and qualifications shall be on duty twenty-four hours a day to carry out the policies, responsibilities, assessed care needs of the residents and	4 089		

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4 089	Continued From page 3 program of the facility; and (2) The numbers and categories of personnel shall be determined by the number, acuity level, and needs of residents. This Statute is not met as evidenced by: Based on observations, record reviews, interviews, and facility policy review, the facility failed to provide sufficient, qualified nursing staff available on a daily basis to meet the residents' needs for nursing care in a manner and in an environment which promotes each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. Findings include:	4 089	4 089 11-94.1-16(b) Governing body and management; Finding #1 To address staffing: • Open positions are actively being recruited with use of agency nurses in the interim • Outside consultant completing position control to ensure staffing adequate for residents' needs • Nursing Home Administrator's job description revised to focus completely in LTC; other responsibilities have been assigned to other managers • DON position in process of being filled - Interim DON will continue to cover until position filled • LTC Medical Director reminded of his duties - NHA will provide supervision to ensure compliance is met; non-compliance to be reported to CEO • Regional Chief Quality Officer started - Quality Program being updated • Infection Control Coordinator (ICC) started - Infection Control Program re-instituted To address education, nurses educated on: • Resident Assessment and deviations from norm • Pain Management • SBAR • Use of paper care plans • Chain of Command to escalate unresolved issues/concerns Facility in process of converting Care Plans from Electronic Medical Records (EMR) back to paper: • Ensure interventions are linked to problems • Provide clear guidance to care givers • Better communication/tracking	11/04/16 11/03/16 08/16/16 10/01/16 11/15/16 10/07/16

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4 089	Continued From page 4	4 089	4 089 11-94.1-16(b) Governing body and management; Finding #2 • Reassign staff, as needed, to cover stations to ensure calls are attended to timely • Per diem positions being filled to supplement staffing, as needed Interim DON will monitor staff completion of assigned education CNE will monitor position control to ensure adequate staffing	11/04/16

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4 089	Continued From page 5	4 089		
4 092	11-94.1-18 Medical director The facility must designate a physician to serve as medical director. The medical director is responsible for: 1) Development, implementation, and evaluation of resident care policies; (2) Coordination of medical care in the facility; and (3) Consultation and training to licensed staff as necessary. This Statute is not met as evidenced by: Based on interview and review of the facility's policies and procedures, the facility failed to ensure the medical director is responsible for implementation of resident care policies; and the overall coordination of medical care in the facility. Finding includes:	4 092	4 092 11-94.1-18 Medical Director • LTC Medical Director rendered his resignation effective 01/02/2017 • During the interim, the current Medical Director will perform the duties of his job relating to: - Implementation of Resident Care policies - Coordination of medical care in LTC - Attend and participate in monthly Medical Executive Committee and Hospital Performance Improvement Committee meetings - Monitoring and oversight of psychotropic medication usage, medication errors and incidence of falls - Attend Medical Staff and HPIC meetings NHA will monitor LTC Medical Director for compliance; non-compliance will be reported to CEO	11/03/16

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4 092	Continued From page 6	4 092	HPIC meetings were held bi-monthly until February 2016: • Quality Director resigned in January 2016 • No HPIC meetings held in February and April • HPIC meetings resumed on Friday, 6/3/16; with subsequent meetings on Thursday, 8/18/16; and Friday, 10/14/16 • Dr. Dupree did attend the 10/14/16, HPIC Meeting • Next meeting scheduled for Friday, 12/2/16	10/14/16

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4 092	Continued From page 7	4 092		

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4 092	Continued From page 8	4 092		
4 130	11-94.1-29(a) Resident abuse, neglect, and misappropriation (a) The facility shall develop and implement written policies and procedures that prohibit	4 130		

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4 130	Continued From page 9 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Statute is not met as evidenced by: Based on observations, interviews, record reviews and facility policy review, the facility did not ensure the residents have the right to retain and use personal possessions, of which possessions such as clothing and jewelry, are kept safe in the facility for 5 of 21 residents in the case sample. Findings include:	4 130		11/04/16 11/08/16

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4 130	Continued From page 10	4 130		

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4 130	Continued From page 11	4 130		10/18/16 10/31/16 11/08/16 11/07/16

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4 130	Continued From page 12	4 130		10/07/16 11/07/16 11/07/16

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4 130	Continued From page 13	4 130		10/06/16 11/08/16 10/06/16

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4 130	Continued From page 14	4 130		
				10/26/16
				11/09/16
				10/26/16
				10/06/16
				11/07/16
				11/15/16
				11/10/16
	In an interview with the Chief Nursing Officer on 10/06/2016 at 2:50 P.M., the facility had a policy on personal belongings but they are working on a new policy to better address resident belongings. The CNO verified that the policy is not 100%			

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4 130	Continued From page 15 clear and there is no standard operating procedure (SOP) for staff to follow. As evidenced by the residents informing the State Agency (SA) of multiple missing personal items, the facility did not ensure a system was in place to safeguard and allow the residents to retain their personal possessions. Many of the residents' personal items remain unaccounted for and no ERFs were generated, contrary to what the facility's own policy states. In addition, interviews of various staff verified this was not being done, and a system to track the residents' missing personal items had not been identified as a quality improvement measure either.	4 130		11/15/16 11/15/16
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on a review of a self-reported incident report (IR) submitted to the State Agency (SA) and investigated through record review, staff interviews and policy and procedure review during the recertification survey, the facility failed to ensure that each resident must receive and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.	4 148		

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4 148	Continued From page 16	4 148		
	Findings include:			10/07/16
				10/10/16
			Licensed ancillary staff re-educated to communicate findings/concerns to Charge Nurse and/or directly to physician	10/07/16
				11/15/16

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4 148	Continued From page 17	4 148		

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4 148	Continued From page 18	4 148		

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4 148	Continued From page 19	4 148		

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	125029	A. BUILDING: _____ B. WING _____	10/07/2016

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4 148	Continued From page 20	4 148		

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4 148	Continued From page 21	4 148		

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4 148	Continued From page 22	4 148		
				10/06/16
				10/06/16
				10/07/16
				10/07/16
				10/10/16
				10/10/16
			Falls Prevention Committee initiated monthly meetings	10/18/16
			Future falls for any resident will require: • Completion of SNF/ICF Post-Fall Quality Improvement Form - Educate staff on use of form and need to pursue more aggressive measures to ensure resident safety - All falls will be routinely reviewed by the IDT to ensure appropriate interventions are taken for patient safety • Care Plans will be reviewed and revised to include other fall prevention interventions • For resident falls with major injury, a RCA will be completed by QRM or RCQO	
			Falls Report to be a standing item on the HPIC Agenda with monitoring and trending by the Quality Department	11/15/16

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4 148	Continued From page 23	4 148		

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4 148	Continued From page 24	4 148		

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4 148	Continued From page 25	4 148		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided.	4 149		

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4 149	Continued From page 26 This Statute is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure that a comprehensive assessment of each resident's functional capacity, including the use of the resident's prescribed medications and knowledge of significant side effects was completed for 1 of 21 residents in the case sample. Finding includes:	4 149		10/11/16 10/11/16 10/07/16 10/21/16
			High Risk Medication Usage reports will be reported to HPIC by the LTC DON as a standing agenda item	11/15/16

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4 149	Continued From page 27	4 149		
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, record review, and interview, the facility failed to ensure food was stored, prepared, distributed and served under sanitary conditions. Findings include: On 10/06/2016 at 1:09 P.M., during an observation and a review of the food temperature log, temperatures were not logged for any food items before, during, or after the dinner meal on 10/03/2016; lunch on 10/04/2016; and no milk temperatures were logged for meals on 10/05/2016. The kitchen helpers verified that temperatures must be taken and logged to ensure that the food remains at a safe temperature during meal preparation and service. In an observation of the kitchen on 10/06/2016 at 12:43 P.M., a cook was preparing Styrofoam "to	4 159	4 159 11-94.1-41(a) Storage and handling of food • Temperature Logs revised to denote staff assigned to checking temperatures - Staff have been educated on the new assignment process Dietary Management will monitor Temperature Logs frequently with: • Corrective education/counseling, as necessary Temperature Log monitoring reports will be reported to HPIC for three consecutive meetings; then quarterly thereafter until 100% compliance is achieved for two consecutive quarters • Dietitian was notified of hand washing deficiency by surveyor - Presented concerns to the employee and reviewed: * hand washing * proper food handling * clean and dirty concepts • Cook IV (Manager) will perform random weekly checks to assure that food is served under sanitary conditions • ICC provided Safe Food Handler Education to all the Dietary Staff - Education will be provided upon hire and then annually for all dietary staff Safe Food Handling monitoring reports will be presented to HPIC for three consecutive meetings; then quarterly thereafter until 100% compliance is achieved for two consecutive quarters	11/01/16 11/04/16 11/15/16 10/06/16 10/06/16 11/01/16 10/27/16 11/15/16

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4 159	Continued From page 28 go trays" for the residents' outing on 10/07/2016. He was writing on the trays by picking them up, one by one; holding the inner part of the container up next to his stomach against his apron; then with a sharpie writing on the trays. During this process he was observed touching several items on the table, wiping sweat from his forehead, and touching his face. He did not wash or sanitize his hands at any time before or during this process. When asked if holding the trays against his clothing was sanitary he verified that he should not be holding them in this manner and agreed that he should have washed his hands before touching the trays. In a meeting with the CNO and DON on 10/07/2016 both acknowledged this would be addressed with dietary and the cook as he verified that he should have washed his hands and should not be holding the trays next to his clothing, but continued this practice after acknowledgement that it was not sanitary.	4 159		
4 166	11-94.1-42(d) Physician services (d) Physicians, physician assistants, or APRNs shall visit the facility as necessary to assure that adequate medical care is being provided, review plan of care, make pertinent recommendations, and determine appropriate level of care of resident. This Statute is not met as evidenced by: Based on a review of a self-reported incident report (IR) submitted to the State Agency (SA), record review, staff interviews and policy and procedure review, the physician failed to take an active role in the supervision of care for one	4 166		

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4 166	Continued From page 29 resident , including the lack of a thorough evaluation of the resident's condition of continued pain, and subsequent delay in the treatment of services for this resident. Finding includes:	4 166	4 166 11-94.1-42(d) Physician services Nursing Staff/Physician will be re-educated to items below • Nursing staff will be required to: - Use SBAR when communicating issues/concerns to physician - Evaluate effectiveness of actions taken - Report unresolved concerns/issues to physician - Remain resident focused and persistent until resolution achieved - Notify NHA or CNE for assistance with physician's non-response to patient care issues • Physician will be required to: - Respond to nurses' phone calls in a timely manner in response to resident's needs - Ask questions to determine resident's specific needs in order to appropriately manage care - Provide follow-up evaluations on timely basis, inclusive of on-site assessments as often as necessary	11/15/16

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4 166	Continued From page 30	4 166		
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on observations, staff interviews and	4 175		

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4 175	Continued From page 31 electronic medical records (EMR)reviews, the facility failed to utilize interdisciplinary expertise to develop a plan of care to improve functional abilities for 2 of 21 residents , in the case sample, and to evaluate and revise the care plan as the residents' status changed. Findings include:	4 175		10/07/16 10/07/16 10/20/16 10/20/16 10/20/16 10/26/16 11/15/16
			Falls Report to be a standing item on the HPIC Agenda	

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4 175	Continued From page 32	4 175		10/11/16 10/28/16 10/28/16 10/28/16 10/31/16 10/31/16

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4 175	Continued From page 33	4 175	Monthly high risk medication reviews will be conducted by Nursing Leadership and Pharmerica RPh with physician involvement	10/21/16

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4 175	Continued From page 34	4 175		
				10/31/16
				10/31/16
				10/31/16
4 198	11-94.1-46(o) Pharmaceutical services (o) A pharmacist shall, on a monthly basis, review the record of all residents receiving medications to determine potential adverse reactions, interactions, and contraindications. The review and any concerns identified shall be	4 198		

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4 198	Continued From page 35 documented in the resident's record. This Statute is not met as evidenced by: Based on observations of resident during the survey, record reviews, interviews and review of the facility's policy and procedure, the facility did not ensure each resident's drug regimen must be free from unnecessary drugs. Residents were found to be on psychotropic medications with no clear indication for use and, the facility failed to ensure that for those residents who use antipsychotic drugs, the behavioral monitoring flowsheets were accurately documented for 8 of 21 residents in the case sample. Findings include:	4 198		11/15/16 10/21/16 & 11/01/16 10/21/16 11/15/16 11/04/16

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4 198	Continued From page 36	4 198		11/15/16

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4 198	Continued From page 37	4 198		10/25/16 10/31/16 10/31/16

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4 198	Continued From page 38	4 198		10/28/16 10/28/16 10/31/16 10/31/16 10/31/16 10/31/16 11/06/16

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4 198	Continued From page 39	4 198		

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4 198	Continued From page 40	4 198		10/31/16 10/31/16 11/01/16

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SAMUEL MAHELONA MEMORIAL HOSPITAL	4800 KAWAIHAU ROAD KAPAA, HI 96746

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4 198	Continued From page 41	4 198		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 198	Continued From page 42	4 198		

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4 198	Continued From page 43	4 198		
				11/01/16
				11/06/16
				11/07/16
				10/10/16

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4 198	Continued From page 44	4 198		
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 interviews and record review, the facility failed to ensure it established and maintained an Infection Control (IC) Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Findings include: On 10/07/2016 at 10:31 A.M., the RCQO, the new Infection Control Preventionist (IP) assigned to the facility, and the Regional Quality Risk Manager (RQRM) were interviewed about the facility's IC program. It was revealed the previous IP had left the facility sometime in the Spring, and the previous DON also left the facility sometime in August 2016. The current administrative staff were unable to provide documentation to demonstrate the components of the facility's current IC program to include how it investigates, controls, and prevents	4 203	4 203 11-94.1-53 (a) Infection control Open Infection Control Coordinator position filled • Infection Control (IC) Logs re-instituted - Staff re-educated on use of logs • IC Policy & Procedure binders made available in every department • Verified isolation rooms (2) ready to use per policy • Risk assessment completed with the following identified: - Influenza spread - Hand washing - Education to providers • Implemented scheduled Flu Vaccination Campaign for employees and residents • Hand washing education is provided all employees upon hire; then annually thereafter • Hand washing monitoring resumed via I-scrub program • IC Policy #125-3-2 Employee Infection Surveillance assigned for employee review • ICC will track/trend IC Log documentation - corrective actions when indicated Infection Monitoring Report will be presented to Infection Control Committee as a standing agenda item including: • Antibiotic usage from Pharmerica • Lab culture reports • Review of IC Log data • Findings from I-scrub program • Employee Infection surveillance • Recommended corrective actions System put in place to ensure that there is adequate coverage for ICC should she be out of office	10/01/16 10/14/16 10/14/16 10/14/16 10/26/16 10/01/16 10/12/16 10/18/16 11/17/16

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4 203	Continued From page 45 infections in the facility, and how it maintains a record of identified IC problems/occurrences and corrective actions taken related to the development and/or prevention of infections. At 11:11 A.M., the IP and RQRM verified they currently had no data with quality indicators/metrics, nor surveillance data or reviews/analyses related to their IC program. In the interim, the RCQO was trying to locate the data which the previous IP and/or DON had, but was unable to produce it.	4 203		
4 292	11-94.1-65(k)(1)(2) Construction requirements (k) The facility corridors shall: (l) Have a minimum clear width of forty-four inches, except that corridors serving one or more non-ambulatory or semi-ambulatory residents shall be not less than eight feet in width; and (2) Stationary handrails shall be installed along both sides of corridors This Statute is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that corridors serving one or more non-ambulatory or semi-ambulatory residents were at least the required 8 feet in width. Finding includes: Based on a re-licensure survey performed by the State Agency in March of 2004, the corridor fronting each nursing station measured less than eight feet in width. The corridor measurements taken at the time of that survey were 7 feet 8 1/2 inches with the widest area being 7 feet 11	4 292	4 292 11-94.1-65(k)(1)(2) Construction requirements • A corridor variance in the LTC building at Samuel Mahelona Memorial Hospital has existed since the 1950's construction. • In order to comply with the corridor 8 foot width requirement, we would have to obtain major capital funding to accomplish the movement of the nursing station to widen the corridor. Therefore, we are requesting a waiver for the corridor width requirement.	11/28/16

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4 292	Continued From page 46 inches. Based on interviews with the CNE and DON, no changes have been made to widen the corridor. The facility will be requesting a waiver as its corridors do not meet this construction requirement.	4 292		