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
	125061	A. BUILDING: ______ B. WING ______	05/19/2017

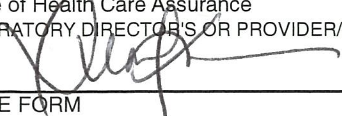
RECEIVED
2017 JUN 13 A 11:05
STATE OF HAWAII
DOH-OHCA MEDICARE

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAUAI CARE CENTER	9611 WAENA ROAD WAIMEA, HI 96796

(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 at the facility from May 16, 2017 thrugh May 19, 2017.	4 000	The submission of this plan of correction does not constitute an admission with the allegations of non-compliance. It is submitted solely as the facility's credible allegation of compliance as mandated by Federal and State regulations. It is the policy of Kauai Care Center that each patient is treated as an individual with dignity and respect.	
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 electronic and hard-copy medical record reviews and interviews, the facility failed to ensure accurate and complete documentation for 2 of 13 residents (R#41 & R#28) on the Stage 2 resident sample list. Findings include: 1) On 05/18/2017 at 1:45 PM, reviewed R#41's electronic medical record (EMR) as the resident was sampled for unnecessary medications. Documentation in the "Nursing Notes," noted that on 05/05/17 the resident ate 100% of meals and supplement with staff assistance, and that R#41	4 105	**4 105 Medical record system** **Corrective Action** This facility will ensure accurate and complete documentation for all residents. This facility will ensure accurate and complete documentation for all residents. Late note was entered on 6/9/17 in R #41's EMR indicating the MAR documentation of NA meant 'Not Applicable" and not "Not Available' and that supplement was in house but resident was not consuming fluids at that time. R #41 Fax to physician was corrected regarding order on allergy line via late note in EMR on 6/9/17. R #28's immunization record was scanned in to the EMR on 6/6/17.	

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 06·09·17



6.13.17-copy to KW;bn

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4 105	Continued From page 1 was alert and pleasantly confused but cooperative with care. The POA (spouse) gave verbal consent for psychotropic medications Haldol/Ativan and verbalized understanding of uses/risks/benefits. Documentation on 5/10/17 noted that R#41 was "very quiet today, no restlessness. Appears comfortable." The resident ate 25% of dinner and drank 240 cc supplement with staff assist. The PCP was in to talk with the family about plan of care and change of orders, the POA verbalized understanding and agreed. The new orders were to "D/C Haldol, Metoprolol, calcium D, ranitidine, aspirin, Megace and Lisinopril. Morphine concentrate 0.125 cc PO Q 4 hrs scheduled, " as resident was on hospice. Documentation on: 5/11/17 at 17:35 noted, "Twocal HN three times a day 120 ml for wt loss and poor appetite. Not available at this time." 5/12/2017 at 16:09 noted, "Twocal HN three times a day 120 ml for weight loss and poor appetite. Not available." 5/13/2017 at 09:34 "Twocal HN three times a day 120 ml for weight loss and poor appetite. supplement not available." 5/13/2017 at 12:58 "Twocal HN three times a day 120 ml for weight loss and poor appetite. supplement not available." 5/14/2017 at 11:22 "Twocal HN three times a day 120 ml for weight loss and poor appetite. na" 5/14/2017 at 18:03 " Twocal HN three times a day 120 ml for weight loss and poor appetite. Two Cal not available." 5/15/2017 at 17:39 " Twocal HN three times a day 120 ml for weight loss and poor appetite. Unable to swallow. Risk for aspiration." On 5/19/2017 at 9:30 AM interviewed Staff#17 and queried whether R#41 was not provided any	4 105	No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. **Responsible Person** Director of Nursing, Nurse Managers and Health Information Manager will be responsible for on-going compliance. **Systemic Changes and Monitoring** In-services were provided to nursing staff from 5/23/17 – 6/3/17 regarding proper documentation in EMR. Nurse Managers will conduct daily audits of orders to physician to ensure proper documentation. Any identified issues will be corrected immediately. Health Information Manager will conduct weekly audits of MAR/TAR documentation to identify any issues with inaccurate documentation by LN's in the EMR. Any identified issues will be corrected immediately. Monitoring will be ongoing for 90 days or until 100% compliance. Health Information Manager will ensure that all required documents are scanned in to resident EMR. Hard copies will remain in paper chart.	

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4 105	Continued From page 2 supplements as noted in the EMR because the facility did not have the ordered supplement. Staff#17 stated that the facility Dietitian made recommendation to the resident's primary care provider (PCP) and if supplement wasn't available the Dietitian would recommend closest that matched ordered supplement. Queried Staff#17 where staff would document that R#41 was provided substitute supplement if ordered supplement was not available. Later Staff#17 returned with documentation found in the certified nurse aides (CNA) EMR, Fluid Monitor, that R#41 began refusing fluids and supplement from 05/05/2017 and that the ordered supplement was always available. Staff#17 did not know why nursing staff documented that supplement was not available instead of resident refused supplement and/or could not swallow. When looking through R#41's hard-copy medical record noticed that fax to the physician dated 4/12/17 noted after "Allergy: Two Cal 120 cc TID." Queried Staff#17 if R#41 was allergic to the supplement ordered and she responded that the supplement order was written on the wrong line, and that the resident had no allergy to the supplement. 2) On 05/19/2017 at 9:45 AM interviewed Staff#17 regarding R#28's 7/2016 TB result for the 2nd step and she had to go research as results were not in the EMR. Staff#17 returned and provided information that in 7/2016, R#28 had a 1-step TB test so the 2nd step was not needed. According to Staff#17, the nurse then mistakenly inputted 2 step TB test but annual TB tests are only 1 step. Also, R#28's immunization hard-copy consent had scanned date of 12/2016 but could not find in EMR, Staff#17 had no explanation.	4 105	**Date of Correction** Compliance will be met by 6/10/17 and on an ongoing basis.	6/10/17

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4 105	Continued From page 3 The facility failed to ensure that medical records were maintained with accurate and complete clinical information about each resident.	4 105	**~~4 120 Resident rights and~~ facility practices** **Corrective Action** This facility will be sure to post contact information for the State Long-Term Care Ombudsman in an accessible area. Resident Council President was informed of the location of the State Long-Term Care Ombudsman contact information on 5/181/7. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. **Responsible Person** The Social Services Director will be responsible for on-going compliance. **Systemic Changes and Monitoring** State Long-Term Care Ombudsman contact information was enlarged and printed on a bright green paper and placed in each bulletin board case at resident eye level. State Long-Term Care Ombudsman contact information was enlarged and printed on a bright green paper and placed on the Activities	
4 120	1-94.1-27(9) 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: (9) The right to names, addresses, and telephone numbers of pertinent resident advocacy groups; This Statute is not met as evidenced by: Based on interviews and observations the facility failed to post contact information for the State Long-Term Care Ombudsman in an accessible area. Findings include: On 05/18/2017 at 10:30 AM, interviewed the facility's Resident Council President and when asked if he knew where to find the State Long-Term Care Ombudsman's contact information, the reply was "No." Staff#25 was asked where to find the information and the surveyor was shown to a glass enclosed bulletin board on the left wall when entering the facility from the main front door. Staff#25 had to point out the information because the Ombudsman contact information was partially obscured by the	4 120		

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4 120	Continued From page 4 bulletin board door frame. The Resident Council President was called over to the bulletin board to find the Ombudsman information and it had to be pointed out to him also. The bulletin board for the facility's back unit also obscured the Ombudsman contact information by the bulletin board door frame. Also, both bulletin boards were placed near the entry/exit doors where it would be unsafe for residents to linger and read contact information for State regulatory and resident advocacy groups. The facility failed to post the State regulatory and resident advocacy groups contact information in a form and manner accessible to residents and resident representatives.	4 120	Calendar board across from Laulima nurses station. State Long-Term Care Ombudsman contact information, along with contact information for OHCA, ADRC Kauai, and the Social Services Director was placed on each resident's personal bulletin board on 5/19/17. Activities Director will audit resident awareness of location of contact information monthly during resident council meeting for the next 3 months to ensure compliance. Results will be reported to QAPI monthly. **Date of Correction** Compliance will be met by 6/10/17 and on an ongoing basis.	6/10/17
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 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Statute is not met as evidenced by: Based on record review and interview with staff member, the facility failed to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress. Findings include:	4 130	**4 130 Resident abuse, neglect, and misappropriation** **Corrective Action** This facility will ensure each resident is safe and prevent further potential abuse, neglect, exploitation, or mistreatment while an investigation is in progress. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency.	

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4 130	Continued From page 5 On 12/9/16 at 6:44 P.M. the facility transmitted an Event Report to the State Agency. The report documents on 12/9/16 at 0606, Resident #42 alleged when a request was made to have lotion applied, a Certified Nurse Aide (CNA) threw the lotion at her. The resident also reported the CNA was "sassy". The facility initiated an investigation, identifying the two CNAs that were assigned on the night shift who provided care for Resident #42 on 12/9/16 (the day of the event). The two CNAs assigned to Resident #42 on 12/9/16 was Staff Member #66 and Staff Member #5. Subsequently a report was transmitted to the State Agency on 12/5/16 at 7:18 P.M. to provide notification that the investigation was completed. The facility concluded the allegation of abuse was not substantiated. The report also documented the CNAs involved were reassigned to another wing until the investigation was concluded. On the morning of 5/18/17 a request was made for the schedule of CNAs from 12/10/16 through 12/16/17. On 5/18/17 at 9:04 A.M. an interview and concurrent review of the schedule was done with the DON. The DON reported Staff Members #66 and #5 both worked on the evening shift on 12/10/16 and 12/11/16 on the unit (Laulima) Resident #42 did not reside. Staff Member #66 worked during the evening shift on 12/13/16 on the Laulima unit. Both staff members worked on the night shift on 12/15/16, assigned to the Laulima unit. A review of the facility's policy and procedures entitled "Abuse/Neglect/Misappropriation" (revised 6/2015) was provided by the facility. The procedure for protection includes the following: "Protecting the resident from further harm means keeping the resident safe by: 1. Immediately	4 130	**Responsible Person** The Administrator will be responsible for on-going compliance. **Systemic Changes and Monitoring** Facility Policy & Procedure (P&P) titled Abuse/Neglect/Misappropriation/Exploitation was updated on 12/13/16. P&P states that staff involved during an alleged investigation will be suspended immediately. All staff will be in-serviced by 6/6/17 – 6/8/17 on updated P&P. Administrator will ensure that during an investigation all staff involved are suspended pending results of the investigation. **Date of Correction** Compliance will be met by 6/10/17 and on an ongoing basis.	6/10/17

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4 130	Continued From page 6 suspend the alleged perpetrator...." On 5/18/17 at 1:00 P.M. an interview was conducted with the Administrator. The Administrator reported the two CNAs were immediately assigned to work on a different unit (Laulima) from the unit where the alleged victim resides as the resident was unable to clearly identify the perpetrator. The policy and procedure was reviewed with the Administrator to immediately suspend the alleged perpetrator and was queried why these CNAs were not suspended. The Administrator replied the resident was unable to identify the alleged perpetrator; therefore, the Administrator used "discretion" and had the CNAs assigned to another unit. Further queried is it the facility's policy to use "discretion" and allow the alleged perpetrators/CNAs to work with other residents. The Administrator acknowledged this is not the facility's policy. On 5/19/17 at 9:00 A.M. the Administrator provided copies of two policies and procedures. The Administrator explained the "Abuse Prevention Program" policy (last updated 7/29/15) was the operational policy during the time of the event. This policy notes under Protection, prevent the resident from sustaining further harm means keeping the resident safe. The "actions that might be implemented include: assuring the alleged perpetrator is kept away from the resident, having a trusted person stay with the resident, allowing the resident to stay in an area which he/she feels safe; and safeguarding the resident's property". The Administrator further reported the policy provided "Abuse/Neglect/Misappropriation/Exploitation" with revised date of 11/2016 was not received until 12/13/16; therefore, the facility followed their	4 130		

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4 130	Continued From page 7 policy and procedure for protecting the resident by reassigning the staff members to another unit. However, the Administrator acknowledged that it is also important to ensure the safety of other residents during the time of the investigation. The facility failed to ensure the safety of the alleged victim and other residents of the facility while the investigation was in progress as the two CNAs continued to provide direct care to other residents during the evening and night shifts during the investigation period (12/9/16 through 12/15/16).	4 130	**4 159 Storage and handling of food** **Corrective Action** This facility will ensure that food is stored for Time/Temperature Controlled and for safety. All food items identified were immediately disposed of on 5/16/17. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. **Responsible Person** Dietary Manager will be responsible for on-going compliance. **Systemic Changes and Monitoring** Staff education was done from 5/23/17 – 5/31/17 which included review of facility policy and procedures related to compliance of food labeling. All food in refrigerated or frozen storage will be labeled and dated to ensure proper food storage as well as food quality. Dietary Manager will do daily checks of all food items stored in refrigeration and freezer units for 90 days or until 100% compliance.	
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 observations and interviews the facility failed to ensure that food were properly stored to ensure safety. Findings include: On 05/16/17 during the initial kitchen tour at approximately 9:30 AM, observed that there were	4 159		

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4 159	Continued From page 8 unlabeled food items stored in the refrigerator and freezer. In freezer #3 there was a bag of frozen french fry cut potatoes that was half used with no open or expiration dates, there were other frozen items that Staff#21 claimed were for personal use and not used for residents. In refrigerator#2 there were unlabeled squeeze bottles of ranch dressing and syrup with no expiration or open dates; opened containers of mayonnaise and grape jelly with no opened date; and a plastic container of chocolate syrup that expired in 2010. According to kitchen staff the chocolate syrup was for personal use and not for residents. In the walk-in refrigerator#4 a container of ranch dressing had an open date of 03/19/17 but no expiration date. The facility failed to keep track of when to discard perishable foods and dating, labeling all foods stored in the refrigerator and/or freezer.	4 159	Interdisciplinary Team will conduct weekly focus rounds to ensure facility P&P is met regarding food labeling and dating. Any and all issues will be reported to daily stand up meeting as well as discussed monthly at Quality Assurance Performance Improvement Committee (QAPI) meetings. **Date of Correction** Compliance will be met by 6/10/17 and on an ongoing basis.	6/10/17
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 observation and interview the facility failed to ensure correct disposition of medications. Findings include: On 18 May 2017, observation of the medication cart on the Lokahi unit, two bottles of Diocto (Docusate) 50mgs/5ml Liquid were found that	4 197	**4 197 Pharmaceutical services** **Corrective Action** This facility will ensure correct disposition of medications. Identified Dicoto Liquid bottles were discarded immediately on 5/18/17. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. **Responsible Person** The Nurse Managers will be responsible for on-going compliance and	

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4 197	Continued From page 9 had discard dates of 4/17 and 12/16. Interview with Staff #16 confirmed that these medications were in place on the medication cart past their discard dates. The facility failed to ensure the two bottles of Diocto Liquid were disposed of after their discard date.	4 197	education of staff on medication administration procedures, including those related to disposition. **Systemic Changes and Monitoring** In-services were provided to nursing staff from 5/19/17 – 6/3/17. Nurse Managers will continue with annual medication administration competency for all licensed nurses. Licensed Nurses will conduct daily audits of medication carts and medication rooms to ensure proper disposition of all expired medications for 90 days or until 100% compliance. Any and all issues will be reported to daily stand up meeting as well as discussed monthly at Quality Assurance Performance Improvement Committee (QAPI) meetings Pharmacy Consultant will continue to monitor medication carts and rooms for expired meds on a monthly basis. **Date of Correction** Compliance will be met by 6/10/17 and on an ongoing basis.	6/10/17
4 283	11-94.1-65(g)(1)(2) Construction requirements (g) The facility shall ensure that floors and walls are maintained as follows: (1) Floor coverings shall be of slip resistant material that does not retain odors and is flush at doorways; and (2) Walls, floors, and ceilings of rooms used by residents shall be made of materials that shall permit washing, cleaning, and painting. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure it was providing a safe environment for residents, staff and the public. Findings include: During observation of the facility's environment on May 16, 2017 during the initial tour, areas of the floor Laulima unit of the facility were buckling creating a trip hazard for residents, staff and the public. The areas of concern on the Laulima unit were located on the ramp outside of the Activities Director's office and on the ramp around the corner to the left. Residents who were self mobile, resided in this area. Other areas of concern were in front of the television in the main common area and an area outside of the meeting	4 283	**4 283 Construction requirements** **Corrective Action**	

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4 283	Continued From page 10 room before the dining room area. Self mobile residents on the Laulima area were exposed to these hazards, along with staff and public who visited the facility. Interview with Staff #24 confirmed these areas identified were a hazard in the facility to residents, staff and public who visited the facility.	4 283	This facility will ensure that it provides a safe environment for residents, staff and the public. Identified flooring issues in the Laulima unit were repaired from 5/19/17-5/30/17. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. **Responsible Person** The Environmental Services Director will be responsible for on-going compliance and safety. **Systemic Changes and Monitoring** Environmental Services Director will conduct daily Environmental Focus Rounds on flooring for the next 4 weeks then weekly for the next 2 months. Then monthly thereafter. Any and all issues will be repaired immediately and reported to daily stand up meeting as well as discussed monthly at Quality Assurance Performance Improvement Committee (QAPI) meetings. **Date of Correction** Compliance will be met by 6/10/17 and on an ongoing basis.	**6/10/17**