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
	125041	A. BUILDING: _____ B. WING _____	04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILIHA HEALTHCARE CENTER	1814 LILIHA STREET HONOLULU, HI 96817

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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: (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: 1) Based on observations, medical record review and staff interviews, the facility failed to provide adequate supervision for Resident #90 (R#90). The facility must ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. Findings include: A review of a self-reported incident report (IR) submitted to the State Agency (SA) was investigated through record review and staff interviews during the recertification survey. 04/20/2017 11:09 A.M. Record review revealed Resident #90 (R#90) was admitted to the facility on 8/11/15 with [redacted] without behavior disturbance, failure to thrive, anorexia, cachexia. dysphagia and hospice. R#90 has a	4 136	Facility formulated a plan of care based on the needs of resident #90 as discussed with family and coordinated with hospice providers. Resident has been in the facility since 8/11/2015 as hospice care following the plan of care of not using any seat belt or waist restraint when this unfortunate accident happened. The following is being done to prevent this from happening again in the future. Corrective Actions Taken: 1. Interdisciplinary team and consultants did a root cause analysis on the fall incident of resident #90. Our Fall Prevention Policy and Procedure was revised incorporating the findings and recommendations. 2. Current residents were reassessed starting on those with past fall incidents to identify factors that may contribute to fall incidents. RECEIVED 2017 MAY -5 A 9:23 STATE OF HAWAII DOH-OHCA MEDICARE	5/2/17 & ongoing 5/2/17 & ongoing

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

Rieswedes E. Santos, MHA — Administrator — 5/5/2017

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4 136	Continued From page 1 frail physique and very poor trunk control. Per the facility, R#90 has a tendency to bend over when sitting in a wheelchair and is kyphotic. R#90 has a history of falls and due to this is is already a high fall risk. On 1/12/17 at 12:45, R#90 fell forward out of her wheelchair, hit her head on the floor and suffered an intracranial hemorrhage, subdural hematoma, laceration to the left eyebrow, bilateral peri-orbital contusions, contusion to upper lip, base of nose and abrasion to left eyelid. A staff member was putting R#90 back into bed. R#90 was placed next to the bed. The staff member stepped away from the wheelchair to draw the curtain closed. R#90 fell out of the wheelchair when the staff member drew the curtain. R#90 was sent to the Emergency Room by ambulance. On 4/20/2017 at 10:34 A.M. interview was done with staff #1. When R#90 came back, we provided a 1:1 sitter for close monitoring and until the daughter felt that her mom was stable. Staff #1 stated "The CNA stated that R#90 was not restless at the time and this could have been prevented if the staff had placed the wheelchair in front of her and not stepped to the side. It was an attended fall. The daughter was really upset. On 04/21/2017 at 11:34 A.M. Interview with Staff #3 R#90 moved to the facility in 2015 because of a hip fracture and was hospice care for over a year. R#90 fell at home and suffered an intratrochanteric fracture and came here. She was cachectic. She requires extensive assist and one to two person assist with transfers. R#90 was able to use wheelchair but most of the time stays in her bed for comfort. She was careplanned for 1-2 person assist with transfers. Staff #3 was asked regarding R#90 that after the fall, they	4 136	3. Licensed nurses will assess residents within 2 days from the date of admission to determine the risk for fall using the Fall Risk Assessment tool. Reassessment is done annually or when a change in condition is identified. 4. Care plan interventions are written based on the result of the assessment and discussed with IDT for their awareness. 5. All residents identified with poor balance and trunk control are referred to physical therapist for their evaluation and recommendation for proper handling, positioning and use of safety devices. 6. Facility will provide therapist recommended devices to residents who are at risk for fall. Nursing staff, DON and MDS staff will continue to monitor proper usage of safety devices daily. 7. Nursing staff meetings were held on April 26 to 5/3/17 and discussed policy on Fall Prevention and restraint use/non-use in the facility 8. See also Plan of Correction for 4 174	5/2/17 & ongoing 5/2/17 & ongoing 5/2/17 & ongoing 5/3/17

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4 136	Continued From page 2 careplanned to make sure bed was in low position, staff will always stand in front of the wheelchair and hold the resident with one hand while pulling the curtain. Staff #3 was asked "when R#90 came in presenting with kphyosis and poor trunk control, was safety measures care planned for wheelchair activity and safety, geri-chair or safety belt? Staff #3 answered no, we did not think of that and we felt that a belt would be a restraint. The facility failed to fully assess the resident's known predisposition to falls concomitant to her clinical condition and presentation on admission. This failure may have contributed to the resident's subsequent fall and injuries on 01/12/17. Based on observations, staff interviews and medical record reviews the facility failed to evaluate and analyze hazards and risks in implementing the use of horizontal metal bar side rails (SRs) to promote the resident's function and/or safety for 3 of 6 residents (R#17, #68 & #138) observed in Stage 1 of the survey, and of 28 residents sampled in Stage 2. 2) Findings include: Cross to F272 Comprehensive Assessments On 04/18/2017 during Stage 1 of the survey, observed R#138, R#17, R#68 lying in bed with bilateral horizontal metal bar SRs with space between the SRs and mattress. On 04/19/2017 at 1:29 PM interviewed Staff#1 and went with her to the bedsides of R#138, R#17 and R#68 to demonstrate that the SRs were loose and shaky when shook and that the resident's limbs could fit through the bars and between the mattress and SRs. The SR safety issue was discussed with both Staff#1 and #2,	4 136	Identification of Other Residents Affected: 1. MDS coordinator and DON will review fall risk assessments to identify residents who are highly at risk for accidents. 2. Residents with history of fall are reviewed using the CAA Review of Indicators for Fall Risk. 3. All staff is encouraged to report all observations to licensed nurse immediately using the STOP and WATCH tool. 4. All residents with a change in condition will be reviewed and update the plan of care as necessary. 5. See also Plan of Correction for 4 174	5/3/17 5/3/17 5/3/17 5/3/17

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4 136	Continued From page 3 and both were not aware of accident risk with horizontal metal bar SRs. Both Staff#1 & #2 were not aware that horizontal metal bar SRs were considered accident risk and just considered restraint issue. The online Food and Drug Administration (FDA.gov) guidance, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," was shared with Staff#1 & #2. On 04/19/2017 at 2:00 PM, R#138's MRR noted that the care plan (CP) "Unsafe behaviors: At risk for injury including: Potential for falls related to : Cognitive loss resulting from vascular dementia with behavior disturbances; limited ROM to upper and lower extremities resulting from atrophy of muscles multiple sites; order of antianxiety; ...as evidenced by: 15 points on fall risk assessment; episode of placing (dangling) both legs off edge of bed. (1/17/17)." The interventions included that R#138 will use bilateral half rails up for safety and to assist with bed mobility. The facility interventions included: to reassess the appropriateness of SRs use every 3 months or as needed and offer total reduction when appropriate; provide/assist needs as appropriate; staff to make sure resident is in the middle of the bed to prevent rolling off the bed; turn and reposition every 2 hrs for comfort; and low bed for safety (1/17/17). The CP was last reviewed on 04/12/17. The Physician Orders (PO), telephone orders on 12/31/16 noted, "May use 2 1/2 top siderails for bed mobility and support; Admit under Islands hospice diagnosis Dementia." On 1/15/17 the PO telephone orders noted, "Re: Clarification of DX: hospice care; vascular dementia with agitation; acute resp failure; pneumonia; dysphagia; hypertension; atrophy of muscle of mulitple sites."	4 136	System Change and Monitoring Changes to Ensure Deficient Practice will Not Recur: 1. MDS coordinator and licensed nurses will make sure that past history of the resident, preferences, cognitive patterns, physical functioning and psychological well-being is being considered when assessing resident condition and in making a plan of care. 2. Resident and/or resident representative will be involved in care planning to make them aware of changes and recommended interventions. 3. Accident prevention interventions will be written on the care plan in the medical records and mini care plan posted for direct caregivers. 4. All staff will continue to observe their resident assignments and are encouraged to report all new or unusual observations to licensed nurse.	5/3/17 & ongoing 5/3/17 & ongoing 5/3/17 & ongoing 5/3/17 & ongoing

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4 136	Continued From page 4 The nursing assessment on 12/31/16 when R#138 was admitted from an acute hospital, described the resident's function in extremities as, "Able to move both upper and lower extremities; both hands closed/clenched most of the time." The Restraint/Positioning Device Assessment form dated 12/31/16 documented, "Restraints: both 1/2 Side Rails up; Bedrails Yes checked; Assist in transfer yes checked." On 04/20/2017 at 2:14 PM reviewed R#138's Hospice MRR and the CP dated 3/30/17 "Problem Falls due to unsafe behavior as evidenced by her dangling both legs on edge of bed;" with the goal that the resident would be without falls; and interventions included: "Assess environment for adequate safety; Assesses need for DAME/Assistive; Ensure bilateral half rails up for safety and to assist with bed mobility." On 04/20/2017 at 7:39 AM the MRR on R#17 noted that the CP, " Unsafe behaviors: At risk for injury including potential for falls r/t Cognitive loss secondary to old cerebral infarction and mixed dementia with behavioral disturbance; limited mobility as a result of old cerebral infarction, right sided hemiparesis; use of atidepressant as evidenced by: 12 points on fall risk assessment; fluctuating alertness; history of leaning on one side when up in her chair; trunk control issues," was last reviewed on 03/25/17. The interventions included: "Provide 2 person assist in transfer; Allow her to sit on by the edge of the bed for at least 60 seconds to prevent dizziness; Use Gait belt at all times for safety; Res will use bilateral half rails up for safety and to assist her with bed mobility and transfer; Will reassess	4 136	5. Interdisciplinary team will discuss concerns during daily QAPI stand-up meetings to identify possible cause of the problem and come up with a specific intervention. 6. QAPI committee will evaluate monthly Quality Indicators which reflects the quality of care provided. 7. See also Plan of Correction for 4 174	5/3/17 & ongoing 5/3/17 & ongoing

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4 136	Continued From page 5 appropriateness of SRS use every 3 months or as needed and offer total reduction when appropriate." The PO dated 9/25/15 for R#17 documented, " May use both 1/2 upper SR up while in bed for safety and mobility." The Restraint/Positioning Device Assessment dated 6/27/16 documented, " Restraints: Bilateral half SR up; Benefits: Enable bed mobility; Risks: Restrict circulation, pressure ulcer, B/B incontinent, anger." The evaluation summary noted, "Resident is to continue using bilateral half rails up to assist her with bed mobility and safety. She has history of CVA with hemiparesis and her trunk balance is poor. She is not restless or attempting to get OOB therefore its not a restraint. No A/R (adverse reaction) from SR use so far." On 04/20/2017 at 1:41 PM, queried Staff#6 on R#17's ability to move. Staff#6 stated that R#17 had periods of restlessness and able to move upper body and sometimes observed with head leaning towards edge of bed. On 04/20/2017 11:02 AM, R#68's MRR documented on the PO dated 3/23/17, "May transfer to low bed with/2 1/2 upper SR up for safety/mobility." On 04/20/2017 at 2:19 PM, Staff#3 provided R#68's "Restraint/Positioning Device Assessment," dated 3/23/17, that noted, "Restraints: Side Rail 1/2 SR; Benefits: Enable bed mobility; prevent rolling/falling out of bed; prevent elopement/fall; comfort/security; Risks: agitation/hostile behavior like kicking, biting; Assessment done: Bedrails yes Fall incident: No."	4 136	KEPT INTENTIONALLY BLANK	

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4 136	Continued From page 6 Interviewed Staff#3 regarding the use of SRs for R#68 and whether assessment on safety with use of horizontal metal bar SRs were done. According to Staff#3, R#68 was placed on an adjustable bed that could be lowered and the SRs provided the R#68 bed mobility, "sanitary reasons," (kept pillows on bed), and able to hang bed alarm from SR. Queried Staff#3 for SR CP and she could not provide it. The facility failed to evaluate and analyze hazards and risks with use of horizontal metal bar SRs and implement interventions to reduce hazards and risks for limb and head/neck entrapment between the loose SRs and mattress for R#138, #17 and #68.	4 136		
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 observations and staff interviews the facility failed to complete comprehensive assessments for the use of horizontal metal bar side-rails (SRs) as an assistive device for bed transfers and safety for 3 of 6 residents (R) (#17, #68 & #138) who were observed with metal horizontal bar side-rails in Stage 1 of the survey, and on the Stage 2 resident sample list of 28 residents.	4 174	Facility will make sure that a comprehensive assessment of all residents will be done to determine appropriate interventions for the plan of care. Corrective Actions Taken: 1. Licensed nurse reviewed and revised the restraint assessment of residents # 138, 17 and 68. Plan of care is updated according to review determination. 2. Residents # 138, 17 and 68 were given a new low electric bed and mattress. Beds are placed in the lowest position when staff is not in attendance.	5/3/17 5/3/17

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4 174	Continued From page 7 Findings include: Cross to F323 Accidents On 04/18/2017 during Stage 1 of the survey, observed R#138, R#17, R#68 lying in bed with bilateral horizontal metal bar SRs with space between the SRs and mattress for limb entrapment. On 04/19/2017 at 1:29 PM interviewed Staff#1 and went with her to the bedsides of R#138, R#17 and R#68 to demonstate that the SRs were loose and shaky when shook and that the resident's limbs could fit through the bars and between the mattress and SRs. The SR safety issue was discussed with both Staff#1 and #2, and both were not aware of accident risk with horizontal metal bar SRs. Both Staff#1 & #2 were not aware that horizontal metal bar SRs were considered accident risk and just considered restraint issue. The online Food and Drug Administration (FDA.gov) guidance, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," was shared with Staff#1 & #2. On 04/19/2017 at 2:00 PM, R#138's MRR noted that the care plan (CP) "Unsafe behaviors: At risk for injury including: Potential for falls related to : Cognitive loss resulting from vascular dementia with behavior disturbances; limited ROM to upper and lower extremities resulting from atrophy of muscles mulitple sites; order of antianxiety; ...as evidenced by: 15 points on fall risk assessment; episode of placing (dangling) both legs off edge of bed. (1/17/17)." The interventions included that R#138 will use bilateral half rails up for safety and to assist with bed mobility. The facility interventions included: to reassess the appropriateness of SRs use every 3 months or as needed and offer total	4 174	3. DON and Administrator met with hospice and DME providers to make them aware that bed with horizontal railings is a risk for entrapment and will no longer acceptable for use in the facility. 4. Hospice residents using hospice rental beds were provided with side rail pads for their safety. 5. See also Plan of Correction for 4 136 Identification of Other Residents Affected: 1. Nursing and maintenance staff checked the type of beds each resident is using. All the beds in use no longer have horizontal rails and space between mattress and rail is not risk for entrapment. 2. Licensed nurse to reassess all residents to make sure that safety device in use is appropriate. Plan of care are being updated according to the assessment results. 3. See also Plan of Correction for 4 136	4/25/17 4/28/17 5/1/17 5/10/17

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4 174	Continued From page 8 reduction when appropriate; provide/assist needs as appropriate; staff to make sure resident is in the middle of the bed to prevent rolling off the bed; turn and reposition every 2 hrs for comfort; and low bed for safety (1/17/17). The CP was last reviewed on 04/12/17. The Physician Orders (PO), telephone orders on 12/31/16 noted, "May use 2 1/2 top siderails for bed mobility and support; Admit under Islands hospice diagnosis Dementia." On 1/15/17 the PO telephone orders noted, "Re: Clarification of DX: hospice care; vascular dementia with agitation; acute resp failure; pneumonia; dysphagia; hypertension; atrophy of muscle of mulitple sites." The nursing assessment on 12/31/16 when R#138 was admitted from an acute hospital, described the resident's function in extremities as, "Able to move both upper and lower extremities; both hands closed/clenched most of the time." The Restraint/Positioning Device Assessment form dated 12/31/16 documented, "Restraints: both 1/2 Side Rails up; Bedrails Yes checked; Assist in transfer yes checked." On 04/20/2017 at 2:14 PM reviewed R#138's Hospice MRR and the CP dated 3/30/17 "Problem Falls due to unsafe behavior as evidenced by her dangling both legs on edge of bed;" with the goal that the resident would be without falls; and interventions included: "Assess environment for adequate safety; Asssess need for DME/Assistive; Ensure bil half rails up for safety and to assist with bed mobility." On 04/20/2017 at 7:39 AM the MRR on R#17 noted that the CP, " Unsafe behaviors: At risk for	4 174	System Change and Monitoring systems to Ensure Deficient Practice will Not Recur: 1. New beds were delivered and installed for residents' use. These beds and devices are LTC compliant and appropriate provides resident comfort, safety and mobility. 2. Nursing staff will continue to monitor behavior of residents. Assessment will be done within 2 days of admission and annually or when there is any change in condition to make sure appropriate device is used for their safety. 3. Facility will provide rubber floor pads next to the low bed of residents who are restless and identified as fall risk. 4. Discussion during IDT daily meetings will include review of identified resident behavior, safety and mobility management. 5. See also Plan of Correction for 4 136	4/28/17 5/1/17 & ongoing 5/2/17 & ongoing 5/2/17 & ongoing

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4 174	Continued From page 9 injury including potential for falls r/t Cognitive loss secondary to old cerebral infarction and mixed dementia with behavioral disturbance; limited mobility as a result of old cerebral infarction, right sided hemiparesis; use of atidepressant as evidenced by: 12 pooints on fall risk assessment; fluctuating alertness; hx of leaning on one side when up in her chair; trunk control issues," was last reviewed on 03/25/17. The interventions included: "Provide 2 person assist in transfer; Allow her to sit on by the edge of the bed for at least 60 seconds to prevent dizziness; Use Gait belt at all times for safety; Res will use bilateral half rails up for safety and to assist her with bed mobility and transfer; Will reassess appropriateness of SRS use every 3 months or as needed and offer total reduction when appropriate." The PO dated 9/25/15 for R#17 documented, " May use both 1/2 upper SR up while in bed for safety and mobility." The Restraint/Positioning Device Assessment dated 6/27/16 documented, " Restraints: Bilateral half SR up; Benefits: Enable bed mobility; Risks: Restrict circulation, pressure ulcer, B/B incont, anger." The evaluation summary noted, "Resident is to continue using bilateral half rails up to assist her with bed mobility and safety. She has hx of CVA with hemiparesis and her trunk balance is poor. She is not restless or attempting to get OOB therefore its not a restraint. No A/R (adverse reaction) from SR use so far." On 04/20/2017 at 1:41 PM, queried Staff#6 on R#17's ability to move. Staff#6 stated that R#17 had periods of restlessness and able to move upper body and sometimes oberved with head leaning towards edge of bed.	4 174	KEPT INTENTIONALLY BLANK	

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4 174	Continued From page 10 On 04/20/2017 11:02 AM, R#68's MRR documented on the PO dated 3/23/17, "May transfer to low bed w/2 1/2 upper SR up for safety/mobility." On 04/20/2017 at 2:19 PM, Staff#3 provided R#68's "Restraint/Positioning Device Assessment," dated 3/23/17, that noted, "Restraints: Side Rail 1/2 SR; Benefits: Enable bed mobility; prevent rolling/falling out of bed; prevent elopement/fall; comfort/security; Risks: agitation/hositle behavior like kicking, biting; Assessment done: Bedrails yes Fall incident: No." Interviewed Staff#3 regarding the use of SRs for R#68 and whether assessment on safety with use of horizontal metal bar SRs were done. According to Staff#3, R#68 was placed on an ajustable bed that could be lowered and the SRs provided the R#68 bed mobility, "sanitary reasons," (kept pillows on bed), and able to hang bed alarm from SR. Queried Staff#3 for SR CP and she could not provide it. The facility failed to do comprehensive assessments on residents that were provided horizontal metal bar SRs for safety and bed mobility. All three residents had the capability of moving and becoming entrapped between the metal bars and mattress.	4 174	KEPT INTENTIONALLY BLANK	
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,	4 175	Corrective Actions Taken: 1. Licensed nurse reviewed and updated the care plan indicating the ordered medication for resident #63. 2. Plan of care indicates when a specific medication is to be given and what to observe as an adverse reaction. 3. DON met with licensed nurses to remind them that all changes in resident condition must be documented in the progress notes and addressed in the plan of care immediately.	5/2/17 5/2/17 5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125041	A. BUILDING: _____ B. WING _____	04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 175	Continued From page 11 and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on medical record reviews (MRR) and staff interviews the facility failed to evaluate and revise the care plan (CP) for 1 of 28 residents (R#63), as the resident's condition changed. Findings include: On 04/21/2017 at 8:41AM the MRR on R# 63 noted on the Physician Order sheet dated April 2017, that the resident was prescribed Trazodone 25 mg as needs for anxiety on 04/12/2017. On the same date the physician also wrote to discontinue Ativan 1 mg. The resident's CP for the problem of " manifesting mood and behavior issues related to vascular dementia as evidenced by: restlessness - gets OOB w/o calling for assistance; verbalization of feeling down , depressed, or hopeless, trouble falling or staying asleep, feeling tired and trouble concentrating," included the intervention of "10. Administer Melatonin as ordered for insomnia." On 04/21/2017 at 10:03 AM reviewed R#63's medication administration record (MAR) with Staff#7, and it was noted that on 4/15/17 the resident was given Trazodone 25 mg by mouth at midnight for distressing anxiety. The facility staff failed to revise the CP interventions for the use of Trazodone when R#63 manifested mood and behavior issues such as anxiety.	4 175	Identification of Other Residents Affected: 1. MDS staff is coordinating with licensed nurses to make sure that care plan is updated for all new medication orders 2. Nursing staff are encouraged to use the Stop and Watch tool to report resident observations. This will be attached to the 24 hour report for communication to all discipline. System Change and Monitoring System to Ensure Deficient Practice will Not Recur: 1. Licensed nurse were reminded to make sure plan of care is updated immediately when a new condition is observed and new medication is ordered. 2. DON, MDS coordinator and licensed nurses will review 24 hour report daily and check to make sure that plan of care is updated for all new orders or change in resident condition. 3. Interdisciplinary team will also review the plan of care during their care plan meeting with resident and/or resident representative. Plan will be updated at this time for any changes and/or omissions.	5/3/17 & ongoing 5/3/17 & ongoing 5/3/17 & ongoing 5/3/17 & ongoing