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
	125052	A. BUILDING: ______ B. WING ______	06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	**78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740**

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4 000	11-94.1 Initial Comments The following reflect the findings of State relicensure Survey with a start date of June 6, 2017 and end date of June 9, 2017. On June 9, 2017, the census was 83.	4 000	THE PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISION OF FEDERAL AND STATE LAW, FOR THE PURPOSE OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLAINCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 7305 OF THE STATE OPERATIONS MANUAL.	
4 136	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 observation, resident and staff interview the facility failed to provide an environment as free from accident hazards as is possible for 1 of 35 residents from the Stage 1 sample. Findings include: 1) On 06/06/2017 at 12:07 PM after interviewing resident (Res) #64 in his room, sitting on his bed, with his O2 running through his nasal canula, noticed a spray bottle on resident's bedside table labled "20 Neutral Disinfectant Cleaner" and	4 136	**Corrective action for identified deficient practice:** As soon as staff were notified that the bottle of disinfectant had been found in the resident room it was removed. **Identifying other areas affected by deficient practice:** On 6/12/17 the Neighborhood Nurse Manager and	7/24/17

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Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature], LNHA
TITLE: Executive Director
(X6) DATE: 7/19/17

7.21.17 - copy to [illegible]

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4 136	Continued From page 1 "Ecolab". Res #64 was interviewed at that time and resident denies using the spray bottle, thought housekeeping might have left it there. Interviewed staff #6 who confirmed that spray bottle with "20 Neutral Disinfectant Cleaner" "it is not supposed to be there", picked up the spray bottle and put it away in the locked medication room on the unit. Review of Safety Data Sheet from Ecolab for 20 Neutral Disinfectant Cleaner from their website (https://safetydata.ecolab.com/svc/GetPdf/20_Neutral_Disinfectant_Cleaner_English?sid=901158&cntry=US&langid=en-US&langtype=RFC1766LangCode&locale=en&pdfname=20_Neutral_Disinfectant_Cleaner_English.pdf) has the following "Hazard statements: Harmful if swallowed or if inhaled. Causes severe burns and eye damage. The Precautionary statements listed are: Wear protective gloves. Wear eye or face protection. Wear protective clothing. Use only outdoors or in a well-ventilated area. Avoid breathing vapor. Wash hands thoroughly after handling." The facility failed to provide an environment as free from accident hazards as is possible for Res #64 which may have resulted in harm if the 20 Neutral Disinfectant Cleaner were swallowed or inhaled.	4 136	Housekeeping/Laundry Director completed a full facility audit of all areas to assure that no chemicals were within reach of residents. **Measures/Systemic Changes:** On 6/10/17 all staff education was completed about assuring that there are no harmful substances in areas where residents could obtain them. The Housekeeping-Laundry Director/designee completes monitoring of each unit to assure that cleaning supplies/chemicals are not accessible in resident areas. Any issues identified as a result of this monitoring will be addressed with one to one education to identified staff member by the Housekeeping-Laundry Director/designee. This monitoring will occur daily for 14 days, then weekly for 60 days or until sustained compliance is achieved. **Monitoring Performance:** The Housekeeping-Laundry Director will provide documentation observations to the Executive Director weekly. Any trends or patterns noted related to the observations will be logged as a problem by the QAPI Committee and corrective action will be taken.	
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	4 174		

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4 174	Continued From page 2 resident/family education. 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 during the recertification survey on June 9, 2017, the facility failed to develop, review and revise the resident's comprehensive care plan. Findings include: On 06/08/2017 record review reveals Resident #191 (R#191) was admitted on 04/07/2017. On 04/17/2017 @ 0745, R#191 returned to their room after physical therapy. Physical therapy left resident standing in the room next to their bed near their bed with front wheel walker. One minute later, R#191 was found on the floor. R#191 sustained a fall on 04/17/2017 that resulted in an injury. At 12:15 p.m. R#191 demonstrated significant changes. R#191 was very sleepy, would not eat and developed nausea and a headache. Emergency medical services (EMS) left the facility at 1330 and took the resident to Kona Hospital. Diagnostic workup at Kona Hospital revealed multiple areas of intracranial hemorrhage with recommendation for Magnetic Resonance Imaging (MRI) for suspicion of cerebrovascular accident (CVA). R#191 was transferred to Queen's Medical Center in Honolulu with multiple bleeds and a questionable CVA. Interview on 06/08/17 at 3:06 P.M. with Staff #5. Staff #5 stated that the resident was not on any blood thinners. R#191's daughter was very involved with decision making. She was hesitant about sending R#191 to the hospital but when	4 174	**Corrective Action for Identified deficient practice:** On 4/17/17 Resident #191 discharged from the facility. **Identifying others affected by the deficient practice:** On 7/3/17 a 100% audit of residents fall care plans/care directives was completed by the Director of Rehabilitation to assure that all had appropriate care plans in place. **Measures/Systemic Changes:** On 6/29/17 the Director of Rehabilitation provided education to facility therapists about updating fall care plans/care directives to assure that changes to resident ambulation status are accurately documented. The Director of Rehabilitation Services will complete a weekly review of therapy progress notes to verify that updates are documented to the care plan/care directive, these audits will be done for 30 days or until sustained compliance is achieved. The results of these audits will be provided to the Executive Director. If areas of concern are noted, The Director of Rehabilitation Services will complete one to one inservice education to therapist. **Monitoring Performance:** Any issues noted related to care plan/care directive updates for changes to ambulation status will be addressed by the Executive Director and corrective action will be reviewed by the QAPI Committee.	7/24/17

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4 174	Continued From page 3 lunch came around and neurological changes occurred, she agreed to send to the hospital. He was then transferred to Kona Hospital and then to Queen's Medical Center. Record Review on 06/08/2017 revealed that R#191 had an initial interim careplan dated 4/08/17. Interventions for interim careplan stated 1) Assist of 1-2 for transfers, standby assist with front wheel walker. 2) Assist of 1-2 for ambulating CGA with front wheel walker. 3) Provide assistance for bed mobility, transfers or ambulation, specific: Staff assist 1-2 person. 4) Monitor and encourage use of proper foot wear. On 4/12/17 physical therapy cleared resident for approximately "150 feet with 4-wheel-walker. The patient is now safe for 4-wheel-walker independent in hallways". Although the physical therapy cleared R#191 for 150', the nursing facility did not update their careplan.	4 174	**Corrective action for identified deficient practice:** On 6/10/17 the Neighborhood Nurse Manager completed education to licensed nurses about documentation expectation for the refrigerator temperature log and the shift to shift narcotic count sign sheet (where nurses are documenting that they are taking the keys and responsibility of the cart). This is in addition to the narcotic count sheet. **Identifying other areas affected by deficient practice:** On 6/12/17 the Neighborhood Nurse Manager completed an audit of temperature logs and the shift to shift narcotic count sheet (where nurses are documenting that they are taking the keys and responsibility of the cart), for each unit to assure that there were no holes in documentation of these logs.	7/24/17
4 194	11-94.1-46(k) Pharmaceutical services (k) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. This Statute is not met as evidenced by: Based on observation, staff interview and review of the facility's policies and procedures on Medication Storage and Controlled Drugs the facility failed to store refrigerated medication at proper temperatures and ensure that the narcotic count sign sheet was signed daily by the oncoming and off going nurses. Findings include:	4 194	**Measures/Systemic Changes:** The Neighborhood Nurse Manager will complete daily audit for 14 days or until substantial compliance is achieved, of the refrigerator temperature logs and the shift to shift narcotic count sign sheet (where nurses are documenting that they are taking the keys and responsibility of the cart). These audits will be reduced to weekly, to be completed by the Neighborhood Nurse Manager. The results of these audits will be forwarded to the Director of Nursing. If concerns are noted the Director of Nursing will complete one to one inservice education to licensed nurse as needed.	

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4 194	Continued From page 4 1) On 06/08/2017 at 10:09 AM while doing an observation of the medication room on the Reflections unit it was noted that the "Temperature Log for Refrigerator-Fahrenheit" form was not filled out completely. Reviewed the temperature log sheet with staff #6 who confirmed that there were missing entries. Staff #6 stated that there are supposed to be 2 temperature checks done daily by the nurses and this is documented on the form along with their initials. One check is done in the "AM" and one in the "PM". On 06/08/2017 at 11:18 AM requested and was given facility policies on "Medication Storage" and "Controlled drugs" by staff #3. Staff #3 was interviewed at this time and confirmed that the nurse managers on the units are responsible for making sure that the medication room refrigerator temperatures and the narcotic count/sign sheet are filled out appropriately. The facility policy and procedure, which is provided by Life Care Centers of America, Inc., "Medication Storage" states " Pharmaceuticals requiring refrigeration must be stored in a refrigerator located in a locked area. The Temperature of the refrigerator must be checked every day." The medication refrigerators were kept in a locked room on the units but a review of temperature logs, facility wide, from January 1, 2017 - June 8, 2017 found 14 days when there were no temperatures documented at all. These were the following dates: January 6, 2017 February 1, 2017 March 1, 2017 March 3, 2017 May 7, 2017 May 16, 2017 May 17, 2017	4 194	**Monitoring Performance:** The Director of Nursing will provide documentation audits to the Executive Director weekly. Any trends or patterns noted related to appropriate recording of refrigerator temperatures or shift to shift keys/cart count sheet will be logged as a problem by the QAPI Committee and corrective action will be taken.	

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4 194	Continued From page 5 May 24, 2017 May 25, 2017 May 26, 2017 May 29, 2017 May 30, 2017 May 31, 2017 June 7, 2017 2) On 06/08/2017 at 11:33 AM reviewed the "Narcotic Count/Sign Sheet" on medication carts 1 and 2 on the Kohala unit and requested that staff #9 make copies of the logs. At that time staff #8 was interviewed about the process that the nurses do to sign the "Narcotic Count/Sign Sheet". It was explained that the two nurses count the narcotics to make sure that the count is correct and then pass the key to the cart onto the next oncoming nurse. Both nurses at that time are to sign the sheet, nurse who is starting their shift (Nurse coming on) and the nurse who is going off of shift (Nurse going off). Review of these logs, facility wide, found that there were numerous occassions when the on coming or out going nurse or both did not sign the "Narcotic Count/Sign Sheet". The "Controlled Drugs" facility policy stated "7. Narcotics are counted at the change of each shift by the off-going and the on-coming nurse and both sign the Change of Shift Count Record." Review of the logs for the Kohala medication cart 1 found nurse coming on signature missing for 06/01/2017 0600-1800 and nurse going off signature missing on 06/01/2017 1800-0600. The Kohala medication cart 2 was missing signatures from it's "Narcotic Count/Sign Sheet" for the following: Nurse going off shift on 04/19/2017 at 0600, 04/30/2017 Nurse coming on 0600-1800, 04/30/2017 Nurse going off 1800-0600, 05/05/2017 Nurse going off 1800-0600,	4 194		

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4 194	Continued From page 6	4 194		

05/06/2017 Nurse coming on 0600-1800, 05/18/2017 Nurse going off 0600-1800.

The Ka'u medication cart had signatures missing from it's "Narcotic Count/Sign Sheet" for the following: 05/12/2017 0600 Nurse coming on and Nurse going off at 0600 and 1800, 05/13/2017 Nurse going off at 0600, 06/01/2017 Nurse coming on at 1800, and 06/05/2017 Nurse going off at 1800.

The Reflections medication cart had signatures missing from it's "Narcotic Count/Sign Sheet" for the following: 05/18/2017 Nurse coming on 1800-0600, 05/19/2017 Nurse coming on and Nurse going off 0600-1800, 05/20/2017 Nurse coming at 0600-1800, 05/20/2017 Nurse going off 1800-0600, 05/31/2017 Nurse going off shift at 0600, 06/05/2017 Nurse coming on at 1800, and 06/06/2017 Nurse going off at 0600.

06/08/2017 at 12:02 PM interviewed staff #6 and asked when the nurses at the facility are trained in how to monitor the medication refrigerator temperature and signing the narcotic count/sign sheet. Staff #6 explained that this occurs when the nurses are orientated on the unit. Staff #6 explained that the nurses are told to check the medication refrigerator thermometer twice a day, at the start of their shift, and document this informaiton on the log.

The facility failed to store refrigerated medication at proper temperatures which may result in a change in potency of medication administered to the residents. The facility failed to monitor nurses for completeness of signing the Narcotic Count /Sign Sheet which may result in poor reconciliation of the narcotics.

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4 203	Continued From page 7	4 203		
4 203	11-94.1-53(a) Infection control	4 203		7/24/17

(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 observation, resident and staff interview and policy review, the facility failed to put practices in place to prevent the spread of infection, including proper hand washing techniques or hand sanitization. The facility is expected to utilize proper personal hygiene practices including proper hand washing to prevent cross contamination.

During observation of medication administration pass with Resident #34 (R#34). Staff #4 passed approximately thirteen medications, of which three were inhalers. Staff #4 was not seen to hand wash or hand sanitize before entering room to pass meds after preparation of medications. Medications were carried into room by Staff #4 without wearing gloves. After R#34 had taken their first puffer, Staff #4 used a tissue to wipe the perimeter of the mouthpiece of the puffer and placed the puffer into her pocket. This process was repeated for three different puffers in which after cleaning with tissue, the puffers were cleaned with a tissue and placed into their pocket. After passing R#34's meds, Staff #34 did hand wash.

Corrective Action for Identified Deficient Practice:

Beginning 7/11/17 the SDC from sister facility and the Director of Nursing provided education to the identified licensed nurse about proper hand hygiene and administration of inhalers.

Identifying others affected by deficient practice: Beginning 7/11/17 licensed nurses were observed by sister facility Nurse Managers and Life Care Center of Kona Director of Nursing, completing medication administration. This included review of administration of inhalers and assuring proper hand hygiene.

Measures/Systemic Changes: Beginning 7/11/17 the SDC from sister facility and the Director of Nursing provided education to licensed nurses about proper hand hygiene during medication administration and proper administration of inhaled medication.

The Director of Nursing/designee will complete discriminate monitoring of 2 nurses on each unit weekly to assure proper hand hygiene and administration of inhaled medication occurs. These observations will continue for 60 days or until substantial compliance is achieved.

Any issues noted as a result of the medication pass observations will be addressed with one to one education from the Director of Nursing.

Monitoring Performance:

The Director of Nursing will provide results of the weekly medication pass observations to the Executive Director weekly. Any trends or patterns noted will be logged as a problem by the QAPI committee and corrective action will be taken.