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
	125009	A. BUILDING: ______ B. WING ______	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	**1027 HALA DRIVE HONOLULU, HI 96817**

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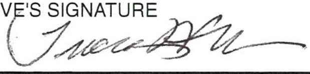
4 000	11-94.1 Initial Comments A recertification and state Licensure survey was conducted on 5/30/2017-6/2/2017. Census at the time of entry was 105.	4 000		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment 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. This Statute is not met as evidenced by: Based on Record Review and interviews, the facily failed to update care plans for 2 of 27 stage 2 residents. Findings include:	4 149	RECEIVED 2017 AUG -3 A 10: 57 STATE OF HAWAII DOH-OHCA MEDICARE	

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE NHA (X6) DATE 8/3/17

8.3.17 - fax copy to EP; bn

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4 149	Continued From page 1	4 149	Continued From Page 1	
	On 06/01/2017 at 1:59 PM reviewed Resident (Res) #50 medical record. Care plan was reviewed and noted that there is a plan in place for risk for Diabetes Mellitus and hemodialysis (HD)-related complications. It was noted that the last review date was 04/17/2017 and next review to be done in July. The care plan stated that the resident "will continue to maintain post HD weights within target weight goal of 105.6 lbs +/- 5 lbs." Reviewed note from the dialysis facility from 05/15/2017 which had the "new DW (Dry Weight) 47 kg" (103.4 lbs) per staff from Liberty Dialysis Hawaii, LLC and this information was not on Res #50 care plan. On 06/01/2017 at 2:46 PM interviewed staff #24 and staff #124 to find out why the "new dry weight 47 kg" was not placed on Res #50 care plan and staff #24 stated that it would be "updated in July" at the next care plan revision. It was explained to staff #24 and #124 the importance of this information that needs to be shared with all the staff who are taking care of this resident to avoid any injury that could result in harm to the resident. The facility failed to update 2 of 27 residents Care Plans from the Stage Two survey sample which may result in injury to the resident.		***HEAD NURSE (HN), CHARGE NURSE (CN), AND REGISTERED DIETITIAN (RD) WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT #50 AFFECTED BY THIS PRACTICE, INCLUDING:*** • To coordinate and monitor the care and condition of the hemodialysis resident, pertinent clinical information is documented on the Inter-facility Communication for Hemodialysis Residents Report by the facility pre-dialysis and by the dialysis center post-dialysis. Upon return to the facility on 05/15/17, the dialysis center had written on this communication report dry weight goal for Res #50. This information was not communicated to the RD. RD called the Head Renal RD at the dialysis center to discuss dry weight for this resident since this was the first time dry weight was noted on this communication report. Head Renal RD instructed parameters for interdialytic weight gains are still 1 to 2 kg (2.2 to 4.4 lbs.) and weight range for dry weight is not used. • Resident #50's care plan has been revised by RD to include dry weights; as recommended by dialysis center's Head Renal RD, goal weight has been removed and replaced by parameters for interdialytic weight gains (1-2 kg).	06-05-17 06-05-17
4 154	11-94.1-40(b) Dietary services (b) All diets prepared for residents shall be: (1) Prescribed by the resident's physician, physician assistant, or APRN with a record of the diet as ordered kept on file; (2) Planned, prepared, and served by qualified personnel according to diet prescription.	4 154		

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		4 149	Continued From Page 2	
			• IDT met to review and update Resident #50's care plan on "Risk for DM and hemodialysis-related complications." Communicate dialysis center recommendations (such as dry weight, changes, labs as needed, nephrologist treatment) have been added to this care plan intervention.	07-06-17
			• HN reviewed with nursing staff resident's updated care plan to share changes such as dry weight goal, updating care plan with any changes in resident's dry weight goal, and communicating recommendations from dialysis center.	07-06-17
			HEAD NURSE (HN), NURSING SUPERVISOR (SRN), AND DIRECTOR OF NURSING (DON) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING:	
			• Residents currently at facility were checked if receiving dialysis treatment. Res #50 is the only resident receiving dialysis.	06-06-17
			HEAD NURSE (HN), NURSING SUPERVISOR (SRN), CHARGE NURSE (CN), AND LICENSED NURSES (LN) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING:	
		4 149	• LN will review the Inter-facility Communication for Hemodialysis Residents Report when resident returns from dialysis and communicate / implement any changes or recommendations made by the dialysis center.	Start 06-05-17 – On-Going
			• When the dialysis center sends notification of new dry weights, LN / HN will communicate new weight to RD by submitting information on the Maluhia Nutrition Referral form and will update care plan(s) by documenting new dry weight and date recommended by dialysis center. If dry weight is used as a goal weight, the interdialytic weight gains (1-2 kg) will be used.	Start 06-05-17 – On-Going
			HEAD NURSE (HN), REGISTERED DIETITIAN (RD), NURSING SUPERVISOR (SRN), AND DIRECTOR OF NURSING (DON) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING:	
			• HN will audit dialysis records & care plans to monitor if updated dry weights and any recommendations are followed through.	Start 07-03-17 – On-Going
			• DON / SRNs will conduct random checks of the Inter-facility Communication for Hemodialysis Residents Report to ensure that dry weight goals and other recommendations are communicated and implemented. Results of the random checks will be shared with the RD. If the above are ineffective, findings of audit will be reported to quarterly QAPI Committee for recommendation and improvement.	Start 07-03-17 – On-Going

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4 154	Continued From page 2 The current Hawaii Dietetic Association Manual or The Manual of Clinical Dietetics of the American Dietetic Association or both shall be readily available to all medical, nursing, and food service personnel; (3) All diets shall appropriately meet the nutrient, texture, and fluid needs of each resident; and (4) Therapeutic or special diets shall be planned by a dietitian and served accordingly as prescribed by the resident's physician, physician assistant, or APRN. This Statute is not met as evidenced by: Based on observations, staff interviews and medical record reviews (MRR), the facility failed to ensure that the physician participated in the nutritional assessment, and that a more in-depth nutritional assessment was done to identify nutrition related risks for 1 of 24 residents (R#129) on the survey Stage 2 sample resident list. Findings include: On 06/01/2017 at 12:03 PM observed R#129 eating lunch in the activity/dining room (rm) on the facility's second floor unit. The resident was able to self-feed the pureed meal served on a divided plate. The resident drank all of the fluids served in 6 ounce plastic cups and also the 1/2 cup of applesauce. After finishing all of the liquids of milk, apple juice, water and pureed applesauce, R#129 started to eat spoonfuls of pureed beef mac casserole and chicken rice soup.	4 154	Continued From page 2a ***REGISTERED DIETITIAN (RD), OCCUPATIONAL THERAPIST (OT), HEAD NURSE (HN), LICENSED NURSE (LN), AND INTERDISCIPLINARY TEAM (IDT) WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT #129 AFFECTED BY THIS PRACTICE, INCLUDING:*** • Resident #129 was placed on Boost Plus 240ml TID between meals on 02/07/17 per family concern due to trial p.o. feeding when gastroenterologist was unable to re-insert GT/JT after resident had pulled out the tube and site had closed.	06-03-17

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4 154	Continued From page 3	4 154	Continued From page 3	

Summary statement of deficiencies (4 154):

The resident was sampled for nutrition due to having a body mass index (BMI) of 18.2 and with no physician ordered supplement.

On 06/01/2017 at 1:01 PM the MRR on R#129, found that the 2/7/17 speech/swallowing therapy evaluation for swallowing recommendations were for pureed solids and honey consistency liquids with feeding by nursing to observe for actual swallow. The residents weight (wt) on 5/24/17 was 87 lbs; 5/10/17 was 89 lbs in the units weight book.

On 06/01/2017 at 1:05 PM interviewed Staff#24 as noted that the last nutritional assessment was done on 2/1/17 after an acute hospitalization for duodenal ulcer perforation when R#129 was on GT feeding. Staff#24 stated that R#129 pulled out his/her gastrostomy tube (GT) on 2/14/17, and was put on intravenous (IV) fluids and pureed diet. The R#129 also pulled out the IV. On 2/15/17 the MD recommended not to replace GT/JT because the resident would continue to pull out tubes and would replace if he/she had poor intake. Since 2/15/17 R#129 received a pureed diet and doing well.

Staff#24 stated that registered dietitian (RD) was included on interdisciplinary (IDT) meetings and provided documentation for the 2/14/17 IDT meeting on R#129, which the RD noted "significant wt loss and resident on TF." Queried Staff#24 if RD did nutritional evaluation after R#129 switched to pureed diet and CN provided that 5/2/17 IDT meeting notes documented, "see RD notes 5/2/17," but Staff#24 unable to locate RD notes. Staff#24 called RD and RD had documentation in her office.

Continued to do MRR and R#129's care plan

Provider's plan of correction (4 154):

This initial supplement regimen was a trial and RD did not write supplement recommendations for physician order. The RD wrote the recommendation to order Boost Plus 120mL TID between meals.

- LN called MD to approve order and updated Physician Order Sheet (POS) and Treatment Administration Record (TAR). — 06-03-17
- Consult with OT in assessing resident's need for assistive device was done and recommended continuation of assistive device (spoon with built-up handle) during meal time. — 06-27-17
- IDT met on 06/27/17 to review and discuss resident's care plan regarding the continued use of the spoon with built-up handle during meals and supplements. — 06-27-17
- HN reviewed with nursing staff to continue to provide supplements and encourage use of spoon with built-up handle during meal time. Resident is using assistive device when feeding self. Staff is to assist resident with eating if resident refuses to use spoon with built-up handle. HN will evaluate usage by resident and consult with IDT and resident's family when resident consistently refuses to use spoon with built-up handle. — 06-27-17

HEAD NURSE (HN), CHARGE NURSE (CN), REGISTERED DIETITIAN (RD), AND LICENSED NURSE (LN) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING:

- Residents currently receiving supplements were identified and POS and TAR were checked to ensure that supplements orders are ordered by the physician and properly documented. — 07-11-17
- HN and IDT checked if any other residents are using assistive devices during meal time; there are none at this time. — 06-26-17

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4 154 Continued From page 4

(CP) #12 dated 5/9/17, " I am underweight related to significant weight loss AEB BMI< 18.5 kg/m2; Weights: 2/1/17: 85.2 lbs; 3/29/17: 85.4 lbs; 4/26.17: 86 lbs." The measurable goals were "I will maintain weight within target weight goal range of 85 to 95 lbs. Interventions: 1. Observe tolerance to Pureed diet, half portion, honey liquids; and, 4. Provide Boost Plus 120 ml TID between meals."

Queried Staff#24 if supplement should be in treatment record. Staff#24 looked at R#129's treatment record and there was no supplement included. Staff#24 went to the unit's refrigerator and Boost Plus 120 ml was on the nourishment tray for R#129. According to Staff#24, the IDT develops each resident's CP and the resident's supplement should have been on the treatment record.

On 06/01/2017 at 2:10 PM interviewed Staff#24 who was find out why the RD didn't reassess R#129 for supplement recommendation after the GT was discontinued on 2/15/17 but she could not provide an explanation. Queried Staff#24, on why supplement was started on 5/17 but sig wt loss was noted at the 2/17 IDT meeting, and she could not provide an answer. The resident's nursing assessment on 3/20/17, documented a wt of 85.2 lbs; and on 3/29/17, wt 85.4 lbs.

On 06/01/2017 at 2:16 PM interviewed the RD and she related that on 2/17/17 the resident's niece and family were convincing R#129 to eat because the resident was refusing to eat and on that date started the supplement on a trial basis to see if the resident would drink the supplement. The IDT progress notes dated 2/17/17 Nutrition Follow-up, documented, "Boost Plus 240 ml PO TID between meals." On the 5/2/17 IDT

4 154 Continued From page 4

REGISTERED DIETITIAN (RD), HEAD NURSE (HN), CHARGE NURSE (CN), AND LICENSED NURSES (LN) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING:

- All commercial nutritional supplements will have MD orders regardless if by trial or by family request. — Start 06-05-17 – On-Going
- If the RD is recommending a supplement and physician order states that the RD may order supplements as needed, the RD will write orders for the supplement as a telephone order. LN will process orders as written, update the POS and TAR, and notify Dietary and write new order on the diet change sheet. LN will call the physician for a telephone order, and MD to sign when he/she comes in. RD will start the supplement for the resident and make the necessary changes to Geri-menu, diet roster and care plans. — Start 06-05-17 – On-Going
- If there is no prior physician order that the RD may order supplements as needed, the LN or RD will write the recommendations on the Physicians Telephone Order slip, (and) place it in the unit's Communication Book. LN will call the physician for approval of recommendations, sign as a telephone order, and update the POS and TAR. When order is received, LN will notify Dietary and write order for the supplement on the diet change sheet for the next morning and update any care plans. The diet aide and/or the RD will start the supplement only when order is received on the diet changes or if notified by phone that a new order is written; Geri menu and diet roster will then be updated. — Start 06-05-17 – On-Going
- HN / CN will review the POS monthly to ensure new supplement orders are included in the following month's printed POS. — Start 06-05-17 – On-Going
- RD will monitor daily diet changes and also keep a file of residents with pending supplement orders to follow up whether supplement recommendation was ordered / approved by MD and if order was sent on diet changes to Dietary. — Start 06-05-17 – On-Going

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4 154	Continued From page 5	4 154	Continued From page 5	

conference notes documentation; "decreased Boost Plus 120 ml TID btw meals d/t improved intakes." Staff#24 and the RD looked through R#129's medical record and could not find an MD order for the supplement.

On 06/02/2017 at 11:01 AM, the MRR on R#129, found a physicians telephone order dated 06/01/17 written with, "(late entry for 5/2/17); 1) D/C Boost Plus 240 ml P.O. TID between meals 2) Decrease to Boost Plus 120 ml P.O. TID between meals." "T.O. Dr. R. Gries," signed by Staff#24.

On 06/02/2017 at 11:42 AM observed R#129's food tray with Staff#24 and Staff#88 in the dining/activity rm. There was a regular spoon on the resident's tray and not a built-up spoon as was ordered by the occupational therapist. According to Staff#24, the resident used the built-up spoon only when dining in-room because they didn't want to misplace the built-up spoon. Staff#88 further stated that R#129 didn't like to use the built-up spoon and would sometimes throw it. Staff#88 went to get the built-up spoon from R#129's rm and stated that she would try to make the resident use it. Discussed with Staff#24 that the use of the built-up spoon should be re-evaluated as resident observed to be using small disposable plastic cups to drink pureed food.

The facility failed to provide nutritional care and services consistent with a comprehensive assessement as the MD did not write the order for nutritional supplements, the built-up spoon was not re-evaluated for use when staff knew that the resident did not want to use it.

Provider's Plan of Correction (continued):

- For all new admissions, HN / CN / LN / SRN will obtain physician approval by checking off on the admission order sheet that the dietitian may order supplements as needed. — Start 07-13-17 – On-Going
- For all current residents who do not have a physician order stating that the dietitian may order supplements as needed, if the resident needs a supplement, the RD will write a recommendation that the dietitian my order supplements as needed at the same time the recommendation for the supplement is written. RD will review all chart orders and write recommendation orders for all current residents who do not have the standing order that the dietitian may order supplements as needed — Start 07-01-17 – On-Going
- HN / IDT will perform comprehensive assessment and recommend if resident could benefit from assistive device to meet nutritional needs. OT will evaluate resident and write recommendation for assistive device on telephone order. LN / HN will call the physician for approval. Recommendation will be written in the care plan and communicated to the staff caring for the resident. CNAs will communicate resident's refusal to use assistive devices on the STOP and WATCH form and notify LN / HN. HN will evaluate usage by resident and consult with IDT to explore continued use and resident / resident's family for alternative treatment option when resident consistently refuses to use spoon with built-up handle. — Start 07-13-17 – On-Going

HEAD NURSE (HN), NURSING SUPERVISOR (SRN), AND DIRECTOR OF NURSING (DON) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING:

- Monthly chart audits comparing POS and TAR with the Diet Roster to monitor orders for supplements are written, have been approved by MD, and are on the POS and TAR correctly. — Start 07-11-17 – On-Going
- Results of the Monthly Audit will be shared with the Clinical Dietitian and summary reported to quarterly QAPI Committee. — Start 08-25-17 – On-Going

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4 174	Continued From page 6		Continued From page 6	
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 record review, resident and staff interview the facility failed to ensure that 1 resident of the 27 Sample Stage 2 residents received proper treatment and assistive devices to maintain their vision. Findings include:	4 154	• DON / SRN will do random checks during meal times to see if resident is using assistive devices as care planned and share findings with HN and IDT findings of these checks will be reported to the Administrator and at the weekly Medicare / IDT meetings.	Start 06-26-17 – On-going
	On 06/01/2017 at 12:09 PM Resident (Res) #123 was observed eating his lunch without use of glasses. At 12:27 PM interviewed Res #123 and resident stated that they do not use glasses and feels their eyesight is "good." On 06/02/2017 at 10:56 AM review of resident's record showed there were no eyeglasses on the property sheet, no care plan for the use of eyeglasses and no mention of the need for eyeglasses in the physical completed by the physician. Interview of staff #4 at that time stated that resident can read without glasses and that resident did not come in with glasses. On 06/02/2017 at 11:30 AM record review of last quarterly MDS, which was completed on 04/21/2017 has the following checked off under vision: "Impaired-sees large print, but not regular	4 174	***HEAD NURSE (HN) AND INTERDISCIPLINARY TEAM (IDT) WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT #123 AFFECTED BY THIS PRACTICE, INCLUDING:*** • HN contacted resident #123's daughter if resident had used eye glasses or any vision aids to read. Per resident and daughter, resident never used eye glasses. Since assessment revealed resident sees large print and not regular print in newspapers / books, daughter brought in reading glasses. Daughter is very involved in resident's care and visits resident almost every evening; she does not feel eye consult is needed at this time. • HN and IDT reviewed / revised ADL care plan. Staff is to offer reading glasses or magnifying glass or reading material with larger print, and provide adequate lighting when reading.	06-05-17 06-05-17

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		4 174	Continued From page 7 ***HEAD NURSE (HN) AND INTERDISCIPLINARY TEAM (IDT) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING:***	
			• MDS B1000 Vision and B1200 Corrective Lenses were checked to identify residents with vision impairment. CAAs and CPs are being reviewed and updated to offer corrective vision aids or magnifying glass or large print reading materials for residents with vision impairment.	Start 06-12-17 – On-Going
			HEAD NURSE (HN), NURSING SUPERVISOR (SRN), CHARGE NURSE (CN), RESIDENT ASSESSMENT INSTRUMENT COORDINATOR (RAI), INTERDISCIPLINARY TEAM (IDT), AND DIRECTOR OF NURSING (DON) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING:	
			• HN / LNs will complete an accurate assessment of residents' visual function upon admission, quarterly / annual assessments, and significant changes. Visual assessment will be done with adequate lighting and with the input of CNAs / Recreational Therapy staff. The MDS B1000 and B1200 will be correctly completed based on this assessment. The CAA for Visual Impairment will be completed when it is triggered. Care plan will be developed / updated with resident / family to address visual impairment and interventions which will include staff offering, assisting and encouraging use of resident's customary visual appliance such as eye glasses, or providing magnifying glasses or larger print reading material.	Start 06-12-17 – On-Going
			• HN will ensure that RAI / IDT reviews and updates care plans based on resident's assessment and resident / family's input	Start 06-12-17 – On-Going
			• HN / CN will communicate assessment findings with resident / family and physician to determine if ophthalmology consult or other recommendations are indicated.	Start 06-12-17 – On-Going
			HEAD NURSE (HN), NURSING SUPERVISOR (SRN), RESIDENT ASSESSMENT INSTRUMENT COORDINATOR (RAI), AND DIRECTOR OF NURSING (DON) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING:	
			• Head Nurse will perform monthly chart review to verify that care plans accurately reflect resident's visual impairment with appropriate corrective interventions to maintain resident's quality of life.	Start 07-03-17 – On-going

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4 174	Continued From page 7 print in Newspaper/books. Interview of staff #28 shared that the resident's family makes their appointments at the VA and that maybe the daughter could bring in glasses for the resident. At that time Res #123 did not have an eye appointment scheduled. On 06/02/2017 at 11:40 AM interview with staff #65 stated that resident was tested for his vision before it was documented in the MDS and the resident was only able to read the large print on the newspaper and not the small print, the coding was done correctly for Res #123. The facility failed to ensure that the resident receive proper treatment and assistive devices to maintain their vision.	4 174	Continued From page 7a • RAI will conduct monthly audit of care plans addressing resident's visual impairment with appropriate corrective interventions. • HN / RAI will submit monthly report of their findings to the DON for review of any deficiencies and DON will report as indicated to the QAPI quarterly committee meeting for further discussion and appropriate interventions. • SRN / DON will randomly attend IDT conferences to ensure that these measures are being carried out.	Start 07-03-17 – On-Going Start 07-31-17 On-Going Start 07-03-17 – On-Going
4 177	11-94.1-44(a) Specialized rehabiiltation services (a) The facility shall provide for specialized and supportive rehabilitation services, including occupational therapy, physical therapy, and speech therapy, according to the needs of each resident, either directly by qualified staff or through arrangements with qualified outside resources. Services shall be programmed to: (1) Preserve and improve the resident's maximal abilities for independent function; (2) Prevent, insofar as possible, irreversible or progressive disabilities; and (3) Provide for the procurement and maintenance of assistive devices as needed by the resident to adapt and function within the resident's environment.	4 177		

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	125009	A. BUILDING: ____ B. WING ____	06/02/2017

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4 177	Continued From page 8	4 177	Continued From page 8	
	This Statute is not met as evidenced by: Based on observations and medical record review (MRR) the facility failed to utilize interdisciplinary expertise to improve range of motion (ROM) for 1 of 24 residents (R#129) on the Stage 2 survey sample resident list.			
	Findings include: On 06/01/2017 at 12:13 PM observed R#129 with splint on the right (R) hand.	4 177	*HEAD NURSE (HN), NURSING SUPERVISOR (SRN), DIRECTOR OF NURSING (DON), AND OCCUPATIONAL THERAPIST (OT) WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT #129 AFFECTED BY THIS PRACTICE, INCLUDING*	
	On 06/01/2017 at 12:37 PM, the MRR on R#129 found that a ROM assessment was last done on 4/28/17. The interdisciplinary conference notes included the rehab report for "U/E Range of Motion: No changes noted with _R#129's U/E ROM this screen...Resident received U/E ROM 2 x/week on unit since her return from acute hospital. Use of R handroll for contracture management and utensil with build-up handle for facilitating in feeding."		• Consult with OT in assessing resident's need for assistive device was done and recommended continuation of assistive device (spoon with built up handle) during meal time. In addition, OT stated use of hand roll is still needed for contracture management to her right hand and has been checking resident's use. For the most part, hand roll has been properly applied and resident has not removed it. HN and OT staff will check placement of hand roll and monitor use.	07-25-17
	The care plan (CP)#2, "I am at risk for further decline in ROM d/t impaired mobility secondary to medical problems;" with "Goals: I will have no further decline in ROM;" and interventions included: "6. encourage me to use utensil with build-up handle for feeding; 7. Use right handroll 2-3 hrs every am and pm shift for contracture management. Check for redness or skin breakdown. Discontinued use of handroll immediately if redness or skin breakdown, & notify CN or OT department; 8. maintenance OT/PT programs 2 x/week UE/LE exercises." Behind the CP#2 were instruction sheets for R handroll use with instructions to place handroll on right hand for 2-3 hours every a.m. and p.m. shift.		• Interdisciplinary Team (IDT) met on 06/27/17 and 07/25/17 to review and discuss resident's care plan regarding the continued use of the spoon with built-up handle during meals and hand roll for right hand contracture management. Resident's family member attended the July 25th IDT meeting and agreed with treatment plan including use of spoon with built-up handle so resident can feed self and use of hand roll to manage right hand contracture. Staff is to assist resident if resident refuses to use spoon with built-up handle. If resident consistently removes / refuses the use, HN will work with OT / IDT for alternative options and communicate with resident #129's family member to obtain input in resident's care.	07-25-17
			• OT recommended continued use of built-up handle to assist with feeding and hand roll for hand ROM.	07-26-17

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4 177	Continued From page 9	4 177	Continued From page 9	
	On 06/01/2017 at 2:32 PM observed R#129 sleeping in bed and the handroll was not placed in R#129's hand, but around the wrist. The resident's family member was at the bedside visiting and stated that R#129 cannot stretch fingers & whenever they try to stretch the fingers R#129 complains, "sore." The family member also tried to use a pressure ball in the hand but R#129 refused. Queried Staff#59 if the resident's handroll was properly placed and Staff#59 stated that R#129 moved the handroll and sometimes will throw it.		Resident to use as tolerated and staff will assist as needed.	
			• Family member communicated concern of resident's pain when she tries to extend fingers of right hand. x-ray of right hand and wrist was done on 07/26/17 with "no definite acute bony abnormality, multi-focal degenerative changes". Family member was notified of the x-ray result.	07-26-17
	On 06/02/2017 at 11:42 AM observed R#129's food tray with Staff#24 and Staff#88 in the dining/activity rm. There was a regular spoon on the resident's tray and not a built-up spoon as was ordered by the rehab therapist. According to Staff#24, the resident used the built-up spoon only when dining in-room because they didn't want to misplace the built-up spoon. Staff#88 further stated that R#129 didn't like to use the built-up spoon and would sometimes throw it. Staff#88 went to get the built-up spoon from R#129's rm and stated that she would try to make the resident use it. Discussed with Staff#24 that the use of the built-up spoon should be re-evaluated as resident observed to be using small disposable plastic cups to drink pureed food.		• HN reviewed with staff resident #129's care plan to encourage use of spoon with built-up spoon during meals and to apply right hand roll 2-3 hours every am and pm shifts for contracture management. HN stressed that if resident refuses the use or removes the spoon with built-up handle or hand roll, Certified Nurse Aide (CNA) will need to report to License Nurse (LN) / Head Nurse (HN) by completing the STOP and WATCH form.	06-27-17
			HEAD NURSE (HN) AND OCCUPATIONAL THERAPIST (OT) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING:	
			• Residents who are using assistive devices during meal time and residents with instructions to apply hand roll for contracture management were identified. Review of documentation, staff interview, and observations determined that hand rolls are being used as recommended by OT. IDT will review / update their care plans to address use of assistive devices during meal time and hand roll for contracture management with input from resident / family members.	Start 06-26-17 – On-going
	The facility did not explore care alternatives through a thorough care planning process in which the resident was able to select from alternative treatments after staff observed that R#129 would throw the built-up spoon and the handroll.		***HEAD NURSE (HN), NURSING SUPERVISOR (SRN), DIRECTOR OF NURSING (DON), AND OCCUPATIONAL THERAPIST (OT) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING:***	
			• Consult with OT in assessing need for appropriate assistive device(s) during meal time and contracture management.	Start 06-19-17 – On-Going

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		4 177	Continued From page 10	
			• OT will document on Telephone Order sheet recommendations for assistive devices during meal times. LN will note recommendation on Physician Order Sheet. OT will continue to communicate to Nursing hand roll instructions and schedule	Start 06-19-17 – On-Going
			• CNAs will follow resident's care plan to offer assistive device(s) during meal time and apply hand roll as scheduled and instructed. CNAs will report to the LN resident's refusal of assistive and contracture management devices on the STOP and WATCH form. If device(s) are not being used due to resident's preference or refusal, HN will consult with OT for appropriateness to continue use or alternative treatment. CN / HN / OT will monitor usage / non-usage and explain to resident/family member importance of treatment plan, risk and benefits, and consequences in refusing/rejecting care. After explanation is given, resident / family member's refusal of treatment will be honored and care planned.	Start 06-19-17 – On-Going
			• HN / CN will encourage resident / family member to attend care plan meetings with IDT to participate in developing / updating their plan of care and communicate their preferences, wishes, and suggestions.	Start 06-19-17 – On-Going
			• HN will ensure that RAI / IDT will develop, review and update care plans based on resident's assessment and resident / family's input and preferences.	Start 06-19-17 – On-Going
			• DON / SRN will attend Resident Council monthly meetings and quarterly Family meetings to encourage residents/family members to participate in their care plan meetings and communicate with care givers their preferences and concerns.	Next Meetings 08-23-17 & 08-29-17
			HEAD NURSE (HN), NURSING SUPERVISOR (SRN), RESIDENT ASSESSMENT INSTRUMENT COORDINATOR (RAI), AND DIRECTOR OF NURSING (DON) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING:	
			• RAI will incorporate adaptive devices such as splints, hand rolls, and special utensils in their monthly Comprehensive RAI / MDS audits.	Start 07-03-17 – On-Going
			• HNs will include adaptive devices such as splints, hand rolls, and special utensils into their monthly QA audits.	Start 07-03-17 – On-Going
			• RAI / HN monthly audits will be submitted to the DON for review of any deficiencies. Findings of QA audits will be reported to the Nurse Managers meeting and as needed to the quarterly QAPI committee for recommendations and improvement.	Start 07-31-17 – On-Going

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4 193	Continued From page 10	4 193	Continued From page 10a	
4 193	11-94.1-46(j) Pharmaceutical services (j) Medication errors and drug reactions shall be recorded in the resident's chart and reported immediately to the physician, physician assistant, or APRN who ordered the drug, and a medication error report shall be prepared and given to the administrator of the facility or director of nursing for review and appropriate action, according to facility policy. This Statute is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 1 resident of the 27 Stage Two sample of residents was free from significant medication error. Finding includes: On 05/31/2017 at 3:00 PM while reviewing Resident (Res) #95 chart and Medication Administration Record (MAR) a medication error was discovered. Res #95 has a doctor's order written on 04/11/2017 for the following medication "Humulin 70-30 vial, inject 18 U SQ q AM and 6 U SQ q PM, If resident eats 25% or less give Humulin 70-30 9 U SQ Q AM and 3 U SQ q PM. Hold if BS<100 mg/dl Dx: DM." Upon reviewing Res #95 MAR it was found that the resident received 9 units of Humulin 70-30 insulin on 05/26/2017 AM dose (0800) with a recorded BS of 84 and resident ate 100% of their breakfast. According to the doctor's order this dose should have been held because Res #95 blood sugar was less than 100. On 05/31/2017 at 3:15 PM met with staff # 20, who had given the 0800 dose of insulin on 05/26/2017 at 0800, to inquire why the insulin was given. Staff #20 looked at MAR and order and stated that it was an "error."	4 193	***HEAD NURSE (HN), NURSING SUPERVISOR (SRN), CHARGE NURSE (CN), AND DIRECTOR OF NURSING (DON) WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT #95 AFFECTED BY THIS PRACTICE, INCLUDING*** • HN / CN observed / assessed resident for hypoglycemic complications, MD and family were notified, and event report form was initiated. • HN / DON reviewed medication error with LN staff #20 and LN was counselled regarding expectations to carefully follow parameters when administering insulin. To prevent medication error, HN / DON reminded LN to consult with CN / HN / SRN if unsure with medication parameters before administering the medication. • HN / SRN / DON checked Resident #95's insulin order and agreed that order with stated parameters was confusing and required clarification.	06-03-17 06-03-17 06-03-17

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		4 193	Continued From page 11	
			• MD visited on 06/01/17 and agreed that insulin order was confusing and discontinued insulin order. MD wrote new order stating, "D/C previous insulin order. Humulin 70/30—give 10u q a.m. and 4u q p.m. Hold if B.S. < 100. Cont BID Accuchek."	06-03-17
			HEAD NURSE (HN), NURSING SUPERVISOR (SRN), CHARGE NURSE (CN), AND DIRECTOR OF NURSING (DON) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING:	
			• All residents with insulin orders were identified and insulin orders were reviewed to ensure that physician orders were clear.	06-08-17
			• HN / SRNs reviewed with LNs that when receiving medication orders, orders must be clear and complete. If orders are complicating, confusing, and / or with too many parameters, LN must follow-up with MD to clarify order. In addition, LNs were reminded to consult with CN / HN / SRN if unsure of parameters before administering insulin.	06-09-17
			HEAD NURSE (HN), NURSING SUPERVISOR (SRN), CHARGE NURSE (CN), AND LICENSED NURSES (LN) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING:	
			• LNs will follow policy and procedures when receiving physician orders and administering medications.	Start 07-13-17 – On-Going
			• HN / SRN / CN will review all insulin orders for clarity (clear and not confusing) to prevent medication error that could result in harm to our residents.	Start 07-13-17 – On-Going
			• HN / SRN will observe all LNs on each unit on a quarterly basis as they administer medication and focusing on insulin administration to ensure that medications are administered as ordered.	Start 07-13-17 – On-Going
			HEAD NURSE (HN), NURSING SUPERVISOR (SRN), AND DIRECTOR OF NURSING (DON) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING:	
			• HN / SRN / DON will conduct random spot checks of medication orders to ensure that insulin orders are clear and not with confusing parameters.	Start 06-08-17 – On-Going
			• HN / SRN will conduct quarterly medication administration audits. These will be reported, summarized, and submitted to the DON who will report the results to the quarterly Pharmaceutical and Therapeutics (P&T) Committee.	Start 07-25-17 – On-Going

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4 193	Continued From page 11 On 06/02/2017 at 10:42 AM met with staff #28 to discuss medication error that occurred on 05/26/2017. Staff #28 reported that staff #20 discussed medication error with them on 05/31/2017 and they filled out the event report and notified the resident's physician and the physician in turn clarified the order. The facility failed to ensure this resident was free from a significant medication error which could have resulted in an injury to the resident.	4 193	Continued From page 11a	
4 199	11-94.1-46(p) Pharmaceutical services (p) When appropriateness of drugs or dosage of drugs as ordered are questioned by the pharmacist or licensed nurse, the licensed nurse or the pharmacist shall consult the physician, and a record of the consultation shall be made available to the administrator of the facility or director of nursing. This Statute is not met as evidenced by: Based on medical record reviews and staff interviews the facility failed to review medications in collaboration with the MD for 1 of 24 residents (R#84) on the Stage 2 survey sample residents list. Findings include: On 06/01/2017 at 8:38 AM the MRR on R#84 found on the June 2017 physician order sheet that the resident was prescribed: Warfarin sodium 1 mg tab (for Coumadin 1 mg tab), 1 tab to be taken by mouth on Mon, Wed, Fri, Sat and Sun for the diagnosis of atrial fibrillation. Also, Warfarin Sodium 1 mg tab (for coumadin 1 mg	4 199	***HEAD NURSE (HN) WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT #84 AFFECTED BY THIS PRACTICE, INCLUDING:*** • HN called MD to clarify Warfarin order since MD recertification visit note for 05/18/17 noted, "Warfarin 2 mg tab, take 1 tablet by mouth once daily on TThSa, Sun and take ½ tab on the other days."	06-05-17

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4 199	Continued From page 12 tab) 2 tabs (2mg) by mouth on Tues and Thurs. for the diagnosis of atrial fibrillation. The facility's pharmacist review dated 5/15/17 noted, "5/3 decrease (drawn arrow pointing down); 5/3 INR 3.1 re-titrate; MD Warfarin update." The lab results for PT/INR done on 5/03/17, had results of ," PT 31.8 secs/ INR 3.1." The physician telephone order on 5/3/17 noted, "Coumadin 1 mg PO on MWFSS and 2 mg PO on TTH. Check Protime in 1 month." The MD progress notes on 5/18/17 for the recertification visit noted on the, "Plan: On coumadin cont medication. Adjust dose as indicated. Q 2 week INR checks...; Medications ordered: Warfarin 2 mg oral tab; Sig - route: Take 1 tablet by mouth once daily on T, TH, Sa, Su and take 1/2 tab on the other days for thinning the blood..." Interviewed Staff#24 to clarify discrepancy of Jun 17 PO and MD visit on 5/18/17 with different orders for Warfarin. Staff#24 had to check with the MD as could not find documentation that new order was clarified with MD. MD report was faxed to facility on 5/22/17 12:36:54 AM. The IDT progress notes on 5/28/17 noted that the MD was notified & staff received telephone order for Robitussin DM Q 6 hr for cough as R#84 was coughing/wheezy earlier that day. The residents CP#13, "I am at risk for possible SE r/t use of Warfarin, " included interventions: "1. Provide medication as ordered. (Warfarin Na). Observe for side effects like bleeding, behavioral changes, skin rashes, etc, document	4 199	Continued From page 12 The Warfarin documentation did not match the existing medication order written on 05/03/17 stating, "Coumadin 1 mg on Mon, Wed, Fri, Sat, and Sunday and 2 mg on Tuesdays and Thursdays" MD stated her recertification visit note was wrong; she will come to the facility to correct it, and to continue Warfarin as ordered. MD came in to the facility at 1400 that same day and corrected her recertification note to keep Warfarin order the same as written previously in MD order. HN wrote a clarification order to keep Warfarin order as written on 05/03/17. ***HEAD NURSE (HN), CHARGE NURSES (CN), AND DIRECTOR OF NURSING (DON) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING:*** • Review most recent MD recertification visit notes and compare with Physician Order Sheet (POS) and Medication Administration Record (MAR) to ensure that medications noted and ordered are the same. If not the same, LNs will contact MD to clarify order. ***HEAD NURSE (HN), NURSING SUPERVISOR (SRN), CHARGE NURSE (CN), AND LICENSED NURSES WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING:*** • DON / HNs instructed LNs to perform drug regimen review by thoroughly reviewing physician recertification visit notes and comparing with the POS / MAR for discrepancies. Any irregularity or discrepancies need to be clarified with the physician. • HN / CN / LN will perform drug regimen review by reviewing physician recertification visit notes and comparing with the current POS / MAR. • HN / CN / LN will contact physician if with discrepancies and will write a clarification order to ensure that resident is given the correct medication, dosage and frequency.	07-13-17 07-13-17 Start 07-13-17 – On-Going Start 07-13-17 – On-Going

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4 199	Continued From page 13 and notify MD as indicated. Lab works as indicated. Notify MD for changes. 3. Check my skin every shift and monitor for early signs of skin breakdown like redness blisters, rashes, bruises or an signs of bleeding, document and notify MD as indicated 5. refer to Pharmacy/MD for drug review and follow recommendations." The facility failed to ensure that R#84 was administered the correct dosage of Coumadin as prescribed.	4 199	Continued From page 13 The review, reconciliation and clarification will be completed within 24 hours after receiving the recertification visit note. HN / LN will write his / her initial, date and time on the physician recertification note to document completion of review and physician notification. ***HEAD NURSE (HN), NURSING SUPERVISOR (SRN), AND DIRECTOR OF NURSING (DON) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING:*** • HN / SRN / DON will do random monthly chart audit to ensure that the drug regimen review, reconciliation, and clarification are performed and completed on a timely basis. • Findings of the audits will be shared with staff during shift reports and at the Maluhia Nurse Managers meetings, for actions and recommendations to improve this practice. Results of the audits will be reported to the facility's Pharmaceutical and Therapeutics (P&T) Committee for further action and recommendations.	Start 07-14-17 – On-Going Start 08-04-17 – On-Going