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
	125058	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE HILO, HI 96720

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4 000	11-94.1 Initial Comments A state relicensure survey was conducted at the facility from 6/27 - 6/30/17. On 6/29/17, the adult day health center was surveyed as part of the annual State re-licensure survey. There are no findings for the ADHC.	4 000		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observation, record review and interview with staff member, the facility failed to ensure 1 (Resident #12) of 29 residents exercised the right to receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Findings include: A review of Resident #12's record found the resident is totally dependent on staff for activities of daily living. The resident is alert and able to	4 115	**4 115** 1. Resident #12's care plan will be reviewed and updated to reflect changes. Resident was assessed for alternative type of call bell actuator as he is better able to trigger this device to call for assistance. 2. All residents will be assessed for appropriate type and placement of call bell actuator by 8/14/17. 3. Weekly x 4 weeks then monthly x 3 months, all residents will be assessed for appropriate type and placement of call bell actuator. Staff will be educated on appropriate types and placement of call bell actuators. 4. Audit results will be reviewed by Director of Nursing or designee months and presented at monthly Quality Assurance meeting x 3 months for review and follow up.	**8/14/17**

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/11/17.

C: KM 8-14-17 pr

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4 115	Continued From page 1 interview. On 6/28/17 at 8:30 A.M. during the initial tour, Resident #12 requested that the surveyor press the call light as it could not be reached. The resident had a splint applied to the left hand and the call light pad was placed on the resident's right pelvic area below the abdominal fold. The resident demonstrated that the call light could not be reached with the right arm or hand. The call light was not affixed to the resident's clothing and was pulled by the cord and placed on the bed, the resident brought the right arm/hand down and was able to press the call light. Resident #12 wanted to call for assistance to get out of bed to attend activity program. On 6/30/17 at 8:00 A.M. a record review found the care plan for activities of daily living with the intervention to encourage Resident #12 to use touch pad to call for assistance, resident prefers to have call bell placed on the stomach and under the right hand. Subsequent observation on the morning of 6/30/17 found Resident #12 in bed. The resident requested the surveyor press the call light which was placed to the right side, approximately at the abdominal fold toward the groin area. The resident demonstrated the inability to raise the right arm to reach the call light. Resident #12 reported the call was to request for assistance to get out of bed to attend activities. Staff Member #1 was called to assist Resident #12. Concurrent observation with the staff member found the call light was not within reach for the resident. The staff member reported the resident is able to move the right arm side to side; however, the call pad was too low to reach. Concurrent review of the resident's care plan with	4 115		

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4 115	Continued From page 2 Staff Member #1 confirmed the intervention is to place the call light on the resident's stomach under the right hand. The staff member reported the call light may have slid off the resident's stomach and applied the clips of the call pad to the resident's clothing. The facility did not ensure reasonable accommodation was provided to enable Resident #12's use of the call light. The call light pad was out of reach for the resident to effectively press the call light.	4 115		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided.	4 149	**4 149** 1. Resident #34's care plan will be reviewed and updated to ensure current interventions are appropriate to resident's current needs. 2. All residents will be re-assessed for their risk for falls by 8/14/17. Fall risk care plans will be reviewed and updated to ensure current interventions are appropriate and in place. 3. Weekly x 4 weeks then monthly x 3 months, 30 resident's fall risk care plans will be audited to ensure current interventions are appropriate and in place. Staff will be educated on following individual care plan interventions. 4. Audit results will be reviewed by Director of Nursing or designee and will be presented monthly x 3 months at the Quality Assurance meeting for review and follow up.	**8/14/17**

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4 149	Continued From page 3 This Statute is not met as evidenced by: Based on observations, electronic medical reviews (EMR) and staff interviews, the facility failed to ensure that implement interventions to reduce fall risks for 1 of 24 residents (R#34), on the Stage 2 sample resident list. Findings include: On 06/29/2017 at 1:51 PM observed R#34 sleeping on a lowered bed with hands holding the grab bars on the left (L) side of the bed. Looked into R#34's EMR and noted on the care plan, "the resident has actual falls related to history of: L hip fracture, Parkinson's disease, dementia with poor safety awareness, and history of falls." The resident had unwitnessed falls on these dates: 10/22/16, 11/06/16, 11/23/16, 12/2/16, 01/25/17, 01/29/17, 03/28/17 (with head injury), and on 05/06/17. The interventions included on "3/18/17 Per resident preference, leave bathroom door open, do not close; "4/22/17 Landing mats to L and R side of bed." Progress notes dated 3/28/17 documented that R#34 was noted with a 3-4 cm hematoma to the top middle of head but denied pain to that area and the neuro checks were within normal limits. The progress note further documented that the resident was found sitting next to the opened bathroom door facing bed, and the resident stated that he was "opening the damn bathroom door because those "f' closed it. It's not supposed to be closed and I fell." The resident also stated that he hit his head on the door. On 06/30/2017 at 8:41 AM observed R#34 in his wheelchair placed next to the nursing station.	4 149		

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4 149	Continued From page 4 When looked into R#34's room there were no landing mats on the sides of the bed and the bathroom door was closed. Interviewed Staff#2, and according to her the resident's landing mats got wet and was removed to be cleaned or replaced but she needed to double check with maintenance. The bathroom door was opened when R#34 was placed back into bed and staff knew to keep door open. The resident started to wheel self around the nursing station and a staff intervened and brought R#34 back to bed. Went to observe R#34 in bed and noticed that the bathroom door was still closed with his wheelchair at the bedside. On 06/30/2017 at 9:28 AM interviewed Staff#3 and she provided that some interventions such as landing mats were resolved 6/5/2017 due to hindrance of level change and R#34 more likely to trip on it; wheelchair at bedside resolved 6/27/17 due to R#34 continually trying to walk around room to find it so to keep wheelchair at bedside; wearing glasses also resolved on 6/27 due to resident removing it. In progress notes Staff#3 wrote, "Reviewed resident's fall CP and current interventions. Resolved interventions that were no longer appropriate for res." Discussed with Staff#3, that the bathroom door was left closed and that intervention was recommended when R#34 fell and hit his head. The facility failed to keep the bathroom door open which they knew if not implemented was very upsetting to R#34, and the risk for another fall.	4 149		

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4 159	Continued From page 5	4 159		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation and interview with staff member, the facility failed to ensure food was stored safely. Findings include: On 6/27/17 at 9:31 A.M. a brief initial tour was done of the kitchen. Concurrent observation with the Food Service Manager (FSM) of the refrigerator found a half-filled tray of bowls with "tapioca pudding" stacked atop other trays with a label to use by 6/19/17. The tray directly under the top tray was full of bowls, the tray was not labeled. The FSM acknowledged the pudding had surpassed the "used by" date as well as the second tray was not labeled. The FSM removed the trays containing the tapioca pudding (the expired ½ full tray and the full try with no label) for disposal.	4 159	**4 159** 1. No individual resident was identified in the survey 2. All residents have the potential to be affected. 3. Dietary staff will be educated on proper method of labeling and discarding food per the facility policy by 8/14/17. Daily x 2 weeks then weekly x 4 weeks then monthly for 3 months, dietary staff will audit refrigerator and freezers for appropriate labeling and discarding food per the policy. 4. Audit results will be reviewed by the dietary manager or designee and will be presented at monthly Quality Assurance Meeting x 3 months for review and follow up.	**8/14/17**