

Hawaii Dept. of Health Office of Health Care Assurance

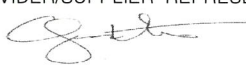
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125030</b>	(X2) MULTIPLE CONSTRUCTION <b>A. BUILDING:-----</b>  B. WING:_____	(X3) DATE SURVEY COMPLETED  <b>07/14/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KAHUKU MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>56-117 PUALALEA STREET KAHUKU, HI 96731</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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4 000	11-94.1 Initial Comments  A relicensure survey was completed at the facility on July 14, 2017. At the time of entrance the census included 5 residents.	4 000	<b>4 000</b> Abatement plan audit tool attached.	
4 092	11-94.1-18 Medical director  The facility must designate a physician to serve as medical director. The medical director is responsible for:  1) Development, implementation, and evaluation of resident care policies;  2) Coordination of medical care in the facility; and  3) Consultation and training to licensed staff as necessary.  This Statute is not met as evidenced by: Based upon record review the medical director failed to coordinate care with the hospice doctor for 1 of 6 residents at the facility.  Findings include:  On 07/13/2017, in the afternoon, tried to contact the medical director and had to leave a voice message that the survey team wanted to set up an interview appointment with him. On 07/14/2017 the DON made arrangements with the medical director to meet with the survey team at 1230 that day to discuss the facility's policy and procedure for admitting residents receiving Hospice care. On 07/14/2017 the medical director did not show up for the scheduled meeting. Interview with the DON and administrator found that the facility had "no policies and procedures in place to receive residents receiving hospice care"	4 092	<b>4 092</b> A Policy and Procedure will be established and implemented that will delineate roles and responsibilities of facility and Hospice entity, by September 15, 2017.  Going forward, individual patient care contracts that are established with Hospice Entities will comply with Kahuku Medical Center established policy and coordination of Medical Care. A check list will be created and implemented upon admission to ensure compliance with policy by the KMC Admissions Coordinator. Check List will be implemented by September 15, 2017.	9/15/2017

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 2017 AUG 21 P 2:14  
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 DOH-OHCA MEDICARE

Office of Health Care Assurance LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephany Nihipali Vaioleti 	President & Chief Executive Officer	08/16/2017

C: BS 8/28/17 pr

Hawaii Dept. of Health Office of Health Care Assurance

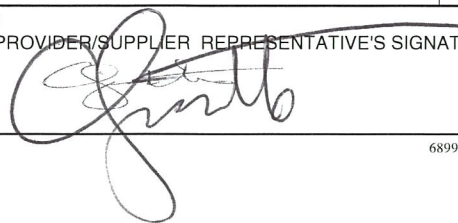
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 2017 AUG 29 P 4:40  
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 DOH-DHCA MEDICARE

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Stephany Nihipali Vaioleti 	President & Chief Executive Officer	08/16/2017

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4 092	Continued From page 1  because "this was a trial resident." The DON and administrator were not sure of the medical director's thoughts on this matter.  The facility medical director, in collaboration with the facility, failed to coordinate medical care and implement resident care policies for a resident receiving hospice care.	4 092		
4 098	11-94.1-21 Arrangement for services  When the facility does not employ a qualified person to render a required or necessary service, it shall have a written agreement or contract with a qualified outside person or provider to provide the needed service.  This Statute is not met as evidenced by: Based on interviews, observations, interviews with staff, the facility failed to maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 1 resident of 6 (Resident #6) residents.  Findings include: Record review for Resident (Res) #6 reveals a 71 year old with a history of end stage chronic obstructive pulmonary disease (COPD) exacerbation, delirium. Res #6 fell at home and her son called the ambulance. Record further states that restlessness is a problem, anxiety as well as delirium. Res #6 was admitted to the facility under the care of hospice. Res #6 has a history of chronic pain and chronic prescription opiate use. Res #6 was admitted to facility on 7/5/17. On 7/7/17, Res #6 fell and sustained a left distal radial fracture at the wrist.	4 098	<b>4 098</b> • CNO will re-educate, Review Falls Policy at the August 17, 2017 Med Surg Staff Meeting. • Have Med/Surg staff sign off on falls policy by 09/01/17 • Implement fall alert within EMR for patients that Morse Falls Score equal to or greater than 45, educate staff at August 17, 2017 Med Surg Staff Meeting. Night Shift Charge RN Chart audit of hourly rounding to be submitted to CNO daily. Staff to be educated at August 17, 2017 Med Surg Staff Meeting.	08/18/2017

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4 098	<p>Continued From page 2</p> <p>Observation 7/11/17 of Res #6 at 9:51 AM who was in room, sleeping perpendicular in bed. No bed alarm heard at this time. Res #6 had white nonskid socks on.</p> <p>Second observation of Res #6 at 10:30 AM on 7/11/17 who was in room laying on bed, sleeping perpendicular in bed. No bed alarm heard at this time.</p> <p>Interview on 07/11/2017 at 11:30 AM with Res #6 who was dozing off and on during the interview and could not keep track of the subject previously spoken during the conversation. She would doze, her body would lean back and when she leaned too far back, she would jerk and she would spontaneously open her eyes from her sleep. Res #6 eyes were pinpoint, fixed. Res #6 appeared over sedated. Res #6 was constantly scratching herself, i.e. arms, legs with noted areas of bleeding and scattered petechiae. Res #6 was also perpendicular in her bed. Res #6 states that she is in pain at the time of dozing off and when she wakes up she forgot that she stated that she had pain. Resident's alarm did not go off. This surveyor sat in room for 20 minutes. There was no bed alarm heard during this time. Res #6 took her brace and Ace wrap off her left wrist and misplaced it in her bed. Record review and concurrent review with Staff #14 on 7/12/17 who gave this surveyor the Hospice folder. Asked staff #14 where the care plans for fall prevention, pain are control and hospice care. Staff #14 confirmed that there were no care plans in the hospice folder for falls, pain control, hospice care/goals, physician orders or a contract between the hospice and the facility. Electronic medical record for the facility revealed there were no care plan for falls, skin or admission</p>	4 098		
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Hawa11 Dept. of Health Office of Health Care Assurance

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4 098 · Continued From page 3	<p>assessment. When asked who the admitting hospice MD was and where the contract for hospice treatment was, Staff #14 did not know.</p> <p>Interview with Hospice staff on 7/12/17 who stated that they have done the care plans and the assessment but they have not been placed in the chart. Hospice staff was asked if they knew about Res #6's fall on 7/7/17. Hospice staff stated that they knew about the fall but the care plan for falls was not submitted to the facility so there would be no update. Hospice staff also acknowledged observation of documents not in chart were assessment, care plans, hospice informed consent for treatment and Hospice physician contract with facility for hospice care. Hospice staff was told that this surveyor observed Res #6 to be overly sedated and what was Hospice's desired level of alertness? There was no care plan addressing concerns of continued need for medications, adjustment and/or discontinuation of medications. Surveyor discussed the responsibilities of coordinated care with the facility for various aspects of Res #6 care. These would include falls and pain management, initiation of care plan and updating of care plans especially with a history of falls and a fall that occurred two days after resident's admission which resulted in injury.</p> <p>Interview with Staff #33 on 7/13/17 who was asked to assist the surveyor with finding any care plans for falls in their charting system. No care plan was produced for falls or skin. A generic care plan was produced for pain which addressed if the expectation for pain control was addressed but no consideration of over sedation, the goals of pain control, adjustment and/or discontinuation of medications.</p>	4 098		
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4 098 i	Continued From page 4  Interview with Staff #5 on 7/13/17 who stated that there was "no care plan for falls done on the nursing side for the facility. I did not see an admission assessment. I'm surprised it was not done. Usually we don't write up care plans, we had to go in and put in the specifics. When we do care plans, we do involve the residents. I wonder if hospice people did it". Surveyor explained "there were no care plans, assessments, and physician orders from the hospice people".  07/12/2017 at 3:20 PM Staff #18 was asked if she could produce a care plan, assessment, an updated care plan or interventions for fall risk. Staff #18 stated they were not able to produce the forms as previously mentioned. "We are doing all of this but we have no documentation". Staff #18 who stated we are supposed to have implemented our National Falls Prevention Program.  In conclusion, the facility failed to do an accurate and complete assessment during Res #6 admission. An admission assessment was not in the electronic medical record. Care plans were not developed for falls, skin and the pain care plan was still in its generic form. Res #6 was admitted under the care of hospice, however, there was no indication of collaboration between the hospice staff and the facility and care plans were not developed to ensure highest possible well-being for end-of-life care. Resident sustained a fall with injury on 7/7/17 resulting in an injury and there was no care plan developed for falls.	4 098		
4102	11-94.1-22(d) Medical record system	4102		

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4 102	<p>Continued From page 5</p> <p>(d) Records to be maintained and updated, as necessary, for the duration of each resident's stay shall also include:</p> <p>(1) Appropriate authorizations and consents for medical procedures;</p> <p>(2) Records of all periods, with physician orders, of use of physical or chemical restraints with justification and authorization for each and documentation of ongoing assessment of resident during use of restraints;</p> <p>(3) Copies of initial and periodic examinations and evaluations, as well as progress notes at appropriate intervals;</p> <p>(4) Regular review of an overall plan of care setting forth goals to be accomplished through individually designed activities, therapies, and treatments, and indicating which professional services or individual is responsible for providing the care or service;</p> <p>(5) Entries describing all care, treatments, medications, tests, immunizations, and all ancillary services provided; and</p> <p>(6) All physician's, physician assistant's, or APRN's orders completed with appropriate documentation (signature, title, and date).</p> <p>This Statute is not met as evidenced by: Based on interviews, observations, interviews with staff, the facility failed to maintain medical records on 1 out of 6 residents (Resident #6) which were complete, accurately documented, readily accessible and systematically organized.</p>	4 102	<p><b>4 102</b></p> <ul style="list-style-type: none"> <li>• MDS Coordinator will review Comprehensive Resident Assessment for LTC using the Resident Assessment Instrument (RAI), MDS and the Care Area Assessment (CAA). Policy Number 49-012</li> <li>• All Med/surg staff to Sign off on policy 49-012 by 09/01/17</li> <li>• Director of Patient Care Services or designee will be responsible to audit all LTC admissions for compliance with comprehensive care planning based off of the MDS within 21 days of admission</li> <li>• Charge RN chart audit for admission assessment</li> <li>• Restructure quarterly interdisciplinary team meeting resident review process – review of MDS results</li> </ul> <p>Director of Patient Care Services/Designee to chart audit review for care plan on one patient per month (patient that is due for that month)</p>	
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4 102	<p>Continued From page 6</p> <p>Findings include:</p> <p>Record review and concurrent review with Staff #14 on 7/12/17 who gave this surveyor the Hospice folder. Asked staff #14 where the care plans for fall prevention, pain are control and hospice care. Staff #14 confirmed that there were no care plans in the hospice folder for falls, pain control, hospice care/goals, physician orders or a contract between hospice and the facility. Electronic medical record for the facility revealed there were no care plan for falls, skin or admission assessment. When asked who the admitting hospice MD was and where the contract for hospice treatment was, Staff #14 did not know.</p> <p>Interview with Hospice staff on 7/12/17 who stated that they have done the care plans and the assessment but they have not been placed in the chart. Hospice staff was asked if they knew about Res #6's fall on 7/7/17. Hospice staff stated that they knew about the fall but the care plan for falls was not submitted to the facility so there would be no update. Hospice staff also acknowledged observation of documents not in chart were assessment, care plans, hospice informed consent for treatment and Hospice physician contract with facility for hospice care. Hospice staff was told that this surveyor observed Res #6 to be overly sedated and what was Hospice's desired level of alertness? There was no care plan addressing concerns of continued need for medications, adjustment and/or discontinuation of medications. Surveyor : discussed the responsibilities of coordinated care with the facility for various aspects of Res #6 care. These would include falls and pain management, initiation of care plan and updating : of care plans especially with a history of falls and</p>	<b>4102</b>		
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4 102, Continued From page 7	<p>a fall that occurred two days after resident's admission which resulted in injury.</p> <p>Interview with Staff #33 on 7/13/17 who was asked to assist the surveyor with finding any care plans for falls in their charting system. No care plan was produced for falls or skin. A generic care plan was produced for pain which addressed if the expectation for pain control was addressed but no consideration of over sedation, the goals of pain control, adjustment and/or discontinuation of medications.</p> <p>Interview with Staff #5 on 7/13/17 who stated that there was "no care plan for falls done on the nursing side for the facility. I did not see an admission assessment. I'm surprised it was not done. Usually we don't write up care plans, we had to go in and put in the specifics. When we do care plans, we do involve the residents. I wonder if hospice people did it". Surveyor explained "there were no care plans, assessments, and physician orders from the hospice people".</p> <p>07/12/2017 at 3:20 PM Staff#18 was asked if she could produce a care plan, assessment, an updated care plan or interventions for fall risk. Staff #18 stated they were not able to produce the forms as previously mentioned. "We are doing all of this but we have no documentation". Staff #18 who stated we are supposed to have implemented our National Falls Prevention Program.</p> <p>In conclusion, the facility failed to do an accurate and complete assessment during Res #6 admission. An admission assessment was not in the electronic medical record. Care plans were not developed for falls, skin and the pain care</p>	4102		
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4 102	Continued From page 8  plan was still in its generic form. Res #6 was admitted under the care of hospice, however, there was no indication of collaboration between the hospice staff and the facility and care plans were not developed to ensure medical records were complete, accurately documented, readily accessible	4 102		
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 and staff interview, the facility failed to ensure 1 of 5 residents (Resident #5) received care in a manner that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality.  Findings include:  On 07/11/2017 at 11:40 AM while waiting for lunch to be served in the dayroom it was noted that resident (Res)# 5 and a patient from the acute side of the hospital were sitting in the	4 115	<b>4 115</b>  • Purchase disposable napkins for all patients. • CNO will educate Nursing Staff in August 17, 2017 Med Surg and CNA meeting about Facilities responsibility regarding Patient Dignity & Respect of Individuality Monthly spot check audits of LTC patients to be completed by Day Shift Charge RN to evaluate compliance of use of disposable napkins and submitted to Director of Patient Care. Compliance Audit Tool to be initiated 9/18/2017	9/18/2017

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4 115	Continued From page 9  dayroom, seated at the table, in their wheelchairs. A staff member went up to Res #5 and placed a white bath towel around their neck and along their chest. This was also done for the patient from the acute side of the hospital. Staff member was asked why they did this and they stated "to protect from food dropping on them". Also during this interaction the staff member referred to the patient from the acute floor as a "feeder." Res #5 was observed during lunch and it was noted that there was little to no spillage of their lunch onto the towel.  The facility failed to treat a resident in a dignified manner.	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	4 149	<b>4 149</b>  • MDS Coordinator will review Comprehensive Resident Assessment for LTC using the Resident Assessment Instrument (RAI), MDS and the Care Area Assessment (CAA). Policy 49-012 • All Med/surg staff to Sign off on policy 49-012 by 09/01/17 • Director of Patient Care Services or designee will be responsible to audit all LTC admissions for compliance with comprehensive care planning based off of the MDS within 21 days of admission • Charge RN chart audit for admissions assessment, present at September 17, 2017 Med Surg Staff Meeting • Restructure quarterly interdisciplinary team meeting resident review process – review of MDS results by 9/21/2017 • Director of Patient Care Services/Designee to chart audit review for care plan on one resident per month (resident that is due for that month)	09/21/2017