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
	125015	A. BUILDING: _____ B. WING _____	09/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAHIAWA GENERAL HOSPITAL	128 LEHUA STREET WAHIAWA, HI 96786

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4 000	11-94.1 Initial Comments A licensure survey was conducted by the State Agency from 9/12/17 through 9/15/17. The census at the entrance was 89 residents.	4 000		
4 125	11-94.1-27(14) 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: (14)The right to personal privacy and confidentiality of personal and clinical records; This Statute is not met as evidenced by: Based on resident interview and record review the facility failed to provide privacy to 1 (one) resident during personal care (Resident #46). Findings include: On 09/12/2017 at 10:23 AM during the resident interview Resident #46 responded that he often has to remind staff several times to close the curtain during and after he receives personal care. People come in to visit the other guy and sometimes the curtain is either open or not closed all the way when I'm naked and uncovered. Resident #46 added that he is very self conscious and very uncomfortable when left exposed. Review of the Care plan dated 12/22/16 states that Resident #46 is totally dependant on staff due to impaired physical mobility and activities of daily living (ADL)	4 125		

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

Rebecca Con-Pat — Administrator — 11/9/2017

STATE FORM 6899 3X5E11 If continuation sheet 1 of 35

... 17 KH recvd. via email from facility; PT

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4 125	Continued From page 1 functions. Resident #46 is alert and oriented to person, place, time and situation. Per review of the Minimum Data Set (MDS) Resident #46 is cognizant with a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact). The facility did not treat the resident in a manner that promotes privacy by leaving the privacy curtain open while providing personal care leaving the resident exposed.	4 125		
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 observations, medical record review and facility staff interviews, the facility failed to ensure the highest practicable psychosocial, mental and physical well-being for 8 (Residents #76, #3, #73, #38, #5, #103, #188 and #165) of 27 residents in the sample related to dialysis, vision, pressure ulcers, accidents and nutrtion.	4 136		

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4 136	Continued From page 2 Findings include: 1) Resident #38 was admitted to the facility in January 2010. He was admitted with diagnoses which included [redacted]; Anxiety Disorder; Depression; and [redacted]. The facility failed to maintain his highest practicable mental, psychosocial and physical well-being as evidenced by his poor hygiene, poor self awareness, aggressiveness, and uncontrolled auditory and visual hallucinations. Observation of Resident #38 on the morning of 9/12/17 at approximately 10:30 A.M. found him lying in bed in his private room with the door closed. Observation of Resident #38 on the afternoon of 9/12/17 at approximately 2:00 P.M. found him lying in bed with the door closed. Three elderly residents were seated close to the nurses station. One staff member was at the nurses station seated at a computer. Observation of Resident #38 on the morning of 9/13/17 at approximately 9:30 A.M. found him lying in bed with the door closed. Observation of Resident #38 on the afternoon found him sitting on his bed in his room with the door closed. Two elderly female residents were seated in the hallway near the nurses station and approximately four rooms lengths from Resident #38's room. All staff members were busy and no one was around. Observation of Resident #38 on the morning of 9/14/17 at approximately 8:15 A.M. found him sitting up in bed with the door closed. Observation of Resident #38 on the afternoon of 9/14/17 at approximately 1:50 P.M. found resident lying in bed with the door closed. A concurrent record review and staff interviews on the morning of 9/15/17 at approximately 9:00	4 136		

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4 136	Continued From page 3 A.M. revealed Resident #38 gets agitated, has auditory and visual hallucinations and often refused daily care. The nurses' notes indicated that Resident #38 was observed taking the yellow "Wet Floor" sign from the cleaning cart and chasing the staff with the sign on several occasions over the past 6 months. According to the nurse's notes, Resident #38 is often observed responding to internal stimuli. He often gets agitated and begins yelling. Sometimes the resident yells at staff. Other times, he is observed yelling at persons who aren't there. The nurses' notes further indicated Resident #38 was routinely observed to have dried feces on his shorts and on his bed linens and his room had a strong odor of feces. The fecal odor from Resident #38's room can be smelled in the hallway when the resident opens the door and goes out into the hallway. Staff #80 reported that Resident #38 preferred staying in his room. He has a long history of attacking staff members. Staff #80 reported the facility made an agreement with their Facilities staff to come over once per week to encourage Resident #38 to shower. Resident #38 was more inclined to obey the Facilities' staff members as they were larger in stature. Staff #80 reported that Resident #38 is ambulatory and continent of bowel and bladder. Staff #80 reported that he thought Resident #38 has bowel movements and doesn't know how to clean himself as the feces was noted to be in the back center area of his shorts. Resident #38 is able to use the toilet to urinate without problems. Staff members in the nursing facility had been attacked by Resident #38 on multiple occasions. Interview of Staff #87 on the morning of 9/15/17 at approximately 9:30 A.M. revealed Resident #38 last attacked her on 9/3/17 when she called the police. Staff #87 stated that the resident said	4 136		

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4 136	Continued From page 4 he wanted to kill her and he attempted to hit her but she got out of the way. Another staff member intervened to stop him. Resident #38 was given Lorazepam prior to the police arriving. Staff #87 stated that when police arrived they refused to take Resident #38 into custody stating the facility was the best place for him. The police apparently informed the facility that Resident #38 was not with it mentally and therefore they couldn't take him into custody as the police wouldn't know how to care for him. Staff #87 reported feeling afraid of Resident #38. She reported the facility has offered psychiatric and psychological counseling for Resident #38 and he has refused all services. Staff #87 stated the facility has attempted to transfer Resident #38 to other long term care facilities, acute care facilities and foster/care homes but none of those agencies were willing to take him. Staff #87 stated that Resident #38's family (parents and a sibling) occasionally visited the resident but refused to take him into their homes. Staff #87 noted the family visits less frequently and his parents reported feeling afraid of Resident #38. An interview of Staff #94 on the morning of 9/15/17 at approximately 10:00 A.M. found she made multiple attempts to find alternative placement options for Resident #38. Staff #94 reported that she's had many conversations with the police. The police informed the facility that they were unable to take the resident out of the facility as it was the best placement option for him. Staff #94 noted that she made attempts to transfer Resident #38 to other acute care psychiatric facilities when he's had psychotic episodes in the past. The acute psychiatric facilities deny the transfer with differing reasons. One acute care facility stated their patient population was admitted via the police	4 136		

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4 136	Continued From page 5	4 136		

department after being arrested and therefore Resident #38 would be at risk of getting injured. Another acute care facility informed Staff #94 that they only took patients referred through their acute care hospital. Staff #87 reported that when Resident #38 gets aggressive, the nurses give him an antianxiety medication via injection which calms him down before the police arrive. When the police arrive, Resident #38 appears calm and cooperative and therefore the police refuse to take him.

An interview of Staff #73 on the morning of 9/15/17 at 10:25 A.M. revealed the staff consistently offered daily care for Resident #38 but she stated he always refused. Staff #73 stated that the Administration will ask the Facilities staff to help and the resident will agree to a shower. Staff #73 reported that Resident #38 yells at the staff. In the past, Resident #38 hit Staff #73. She reported feeling afraid of the resident. Staff #73 said the police often come when Resident #38 gets aggressive but they never take him into custody. The police consistently tells the staff that Resident #38 is already in an institution. Staff #73 stated Resident #38's room has a strong foul odor. She noted seeing feces from his bed to the bathroom. Staff #73 said Resident #38 can toilet himself but he doesn't really know how to clean himself and refuses to allow the staff to help him. Staff #73 further added when they try to assist Resident #38, he yells at the staff and slams the door. Staff #73 sometimes enter Resident #38's room alone but if possible will go with another staff member.

In addition to his aggressiveness, Resident #38 frequently refuses medications and daily care. On the morning of 9/15/17, a review of the

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4 136	Continued From page 6 nurse's notes found Resident #38 refused medications eight times over the past month (8/16/17 to 9/15/17). A review of Resident #38's Activities of Daily Living (ADLs) over a period of one month (8/16/17 to 9/15/17), found he had 3 showers and 4 bed baths. Staff offered Resident #38 a bed bath on every shift every day but he refused most of the time. The staff offered him showers on his scheduled days which he also refused. Aside from the 3 showers and 4 bed baths in 30 days, Resident #38 had refused all other opportunities for bed baths and showers. A review of Resident #38's annual Minimum Data Set (MDS) on the morning of 9/15/17 at approximately 9:30 A.M. with an Assessment Reference Date (ARD) of 8/11/17 noted under Section C. Brief Interview of Mental Status (BIMS) score of 12/15 indicating moderately impaired cognitive status. Section E. Behavior noted that during the look back period, Resident #38 experienced: Hallucinations; Verbal behavioral symptoms toward others 1-3 days; Behaviors significantly interfered with resident's care; Behaviors put others at significant risk of physical injury; Rejection of care for 4-6 days; and Resident has wandered on 1-3 days. Section G. Functional status noted Resident #38 only required supervision with Activities of Daily Living (ADLs). Exceptions included: Dressing - activity occurred only once or twice; and Bathing with which he was totally dependent requiring one person physical assistance. A review of Resident #38's care plan noted Resident's long history with aggressive behaviors, including: Yelling and threatening staff; Hitting staff with a cane (6/25/16); Hitting staff with his fist (6/27/16); Held a cane and went to another resident's room yelling, "That man used to be	4 136		

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4 136	Continued From page 7	4 136		

next to my room and I hate him" (11/17/16); Held a removable IV pole and refused to give it back (11/9/16); Held a wet floor sign, yelling many times (11/10/16); Held an IV pole in hallway and was yelling (11/14/16); Verbal altercation with another resident (3/9/17); Threatened to hit staff (3/20/17). Although not listed in Resident #38's care plan, his aggressive/disruptive incidents continued on a regular basis. On the morning of 9/15/17, a review of the nurse's notes revealed Resident #38's hallucinations and aggressive behaviors regularly occurred up until the time of survey. Resident #38 refused medications at least once per week and displayed aggressive behaviors almost daily. The nurse's notes demonstrated Resident #38 gets agitated and or aggressive with staff and or other residents at least one time per week. The staff attempts to redirect the resident but are not always successful.

An interview of the Administrator on the morning of 9/15/17 at approximately 10:00 A.M. revealed her knowledge of Resident #38's medical and behavioral history. She reported the facility's frustration with getting help for this resident, whom the facility was not equipped to care for. She stated the facility has had lengthy discussions of options for Resident #38 and have concluded they would maintain him at his current level of functioning. She noted that she provided Resident #38's parents with a discharge letter informing them that the facility would discharge him in 30 days from the date of the letter. The resident's parents never responded to the discharge letter and the facility did not pursue discharge of the resident.

At the time of survey, the facility was unable to provide the necessary care and services for

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4 136	Continued From page 8 Resident #38, despite their efforts and attempts. The facility staff did not have the necessary training and skills to care for Resident #38. Additionally, the facility was unable to provide the necessary environment to maintain Resident #38's highest practicable behavioral, physical and psychosocial well being. 2) On 09/13/2017 at 12:22 PM reviewed R#73's EMR as the resident was sampled for dialysis in Stage 2 of the survey. The care plan (CP): "The resident needs hemodialysis related to renal failure," noted that the resident was alert and able to make decisions for daily needs; resident is noncompliant at times to diet; and refusing hemodialysis due to diarrhea or pain, related to constipation. The interventions included: assist resident to go for the scheduled dialysis appt; Resident receives dialysis TTH and Sat, ... On 09/13.2017 at 12:24 PM interviewed Staff#87 and she stated that R#73 goes to dialysis on Mon, Wed and Fri from 4:45 - 8:30 PM. In the residents EMR under the Orders tab was documented, "Dialysis Mon, Wed, Fri." On 09/13/2017 at 1:17 PM reviewed R#73's EMR with Staff#76 to clarify where the nursing staff documented patency of resident's fistula. Staff#76 found under the "Progress Note" tab a template, "Assess patency of fistula; Fistula location: Left arm; Every shift document bruit - strong, faint or absent; Document thrill - strong, faint or absent." Discussed with Staff#76 template documented as above, with bruit and thrill (B/T) characteristics not underlined or circled, and not specific for exactly what the nurses assessed. Staff#76 stated that treatment administration record (TAR) was used to	4 136		

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4 136	Continued From page 9 document B/T per shift. Looked at TAR with Staff#76 and found documentation on: 9/11/17 NOC no fistula assessment for Bruit/Thrill; 8/3/17 NOC and 8/7/17 NOC Bruit/Thrill =0; 8/20/17 NOC no fistula assessment. Staff#76 made note of missing documentation and stated that will be discussed with nursing staff that progress note template needs to be specific. On 09/14/2017 at 2:42 PM the medical record review (MRR) on R#73 found that the interdisciplinary (IDT) meeting on 8/18/16 documented, CP# Health Care deficit hemodialysis - "Tue, Thur, Sat r/t renal failure tolerating well," "Tues, Thurs, Sat was crossed out and MWF was written above in ink). The facility did not ensure that R#5 received dialysis care that was consistent with professional standards of practice. 3) Cross Reference to §11-94.1-43 (b). Resident #76 was admitted on 12/02/16 to the facility with a diagnosis including: Diabetes Mellitus type 2, diabetic neuropathy, primary hypertension, transient ischemic attack and cerebral infarction without residual deficits. On 9/13/17 at 9:30 A.M. Resident #76 was observed to be awake and alert and resting in bed. On 9/14/17 at 12:30 P.M. a review of the quarterly Minimum Data Set (MDS) with assessment reference dates of 5/26/17 and 8/18/17, Resident #76 yielded a score of 2; moderately impaired-limited vision, not able to see	4 136		

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4 136	Continued From page 10 newspaper headlines but can identify objects and not having corrective lenses. On 9/14/17 at 2:40 P.M. Resident #76's care plan was reviewed indicating there were no goals or interventions developed to address the vision deficit documented in the resident's assessment. At 1:48 P.M. during an interview with Staff #2, when asked if Resident #76 was able to see, Staff #2 responded that Resident #76 can't see very well and could use glasses. At the request of the surveyor, Staff #2 reviewed the Electronic Medical Record and revealed there was no Ophthalmology consultation for Resident #76 for a vision exam. At 1:52 P.M. the MDS Coordinator reviewed the care plan and concurred with Staff #2 that there is nothing written in the care plan to address the resident's visual deficit. Staff #67 stated that the care plan will be updated and the family contacted to assist the Resident with an eye exam and to obtain glasses. The facility failed to provide necessary care and services to ensure Resident #76 received proper treatment and assistive devices to maintain his vision. 4) Resident #3 was admitted to the facility on 12/27/2003. The diagnoses include: hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side; nutritional deficiency, unspecified; conversion disorder with seizure or convulsion; dysphagia, oropharyngeal phase; and pressure ulcer of other site, Stage 3. On the morning of 9/12/17 a record review and interview with staff member found Resident #3 with a Stage 3 pressure ulcer to the right	4 136		

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4 136	Continued From page 11 posterior shin. Further review documented on 4/2/17, Resident #3 had a Stage 2 pressure ulcer to the right heel which was now "suspected deep tissue injury". On 9/12/17 at 9:55 A.M., Resident #3 was observed asleep in bed laying on his back. Subsequent observation at 2:00 P.M. found the resident asleep with bilateral upper rails raised. On 9/13/17 at 1:48 P.M. Resident #3 was observed lying in bed asleep, on his right side, a pillow was placed under his back on the left. The resident's left leg was bent up toward his torso with the right leg under the left. On 9/14/17 at 9:25 A.M. Resident #3 was observed with the therapist. The resident was awake lying in bed. The therapist confirmed they were working on a way to float the resident's heels and demonstrated the use of three pillows; however, the resident's heels still touched the mattress. Inquired where the resident had a Stage 3 pressure ulcer, the therapist looked at the back of the resident's calf, the skin was observed to be mottled with brown spots, the therapist located a small scab and surmised this was the healing pressure ulcer. Subsequent observation at 10:31 A.M. found the resident asleep with pillows under his legs and a pillow between his legs. Observation on the morning of 9/15/17 found the resident sitting in his wheelchair with rolled up towels between his knees/calves. On the afternoon of 9/13/17 a record review found a physician's order to apply skin sealant to right lower posterior leg wound as well as order for supplements (promod and juven) for wound healing (Stage 3 pressure ulcer to lower extremity). A review of the progress note dated 8/6/17 documents a Certified Nurse Aide (CNA) notified the nurse of a wound on the resident's	4 136		

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4 136	Continued From page 12 lower leg. The nurse documents finding a wound with "irregular edges with cream colored tissue on the center". No bleeding noted. The area was cleansed with normal saline and covered with a dry dressing. Further review found "Weekly Pressure Ulcer/Wound Assessment - V1" dated 8/6/17, initial assessment. The wound measured 2 cm (length) x 2 cm (width). This wound was documented as a new pressure ulcer which was healthcare acquired. There was yellow drainage noted to the wound and the plan was to consult the wound nurse. Subsequent assessment was done on 8/9/17 by the wound nurse. The assessment documents the pressure ulcer is new and was healthcare acquired. Listed under the cause of skin problems included: pressure and cerebrovascular accident with left-sided weakness and resident tends to cross his legs while up in the wheelchair. The site identified was right lower leg (rear) with the following measurements: 1.5 cm (length) x 1.5 cm (width) x 0.3 cm (depth). Also noted was a scant amount of serosanguineous drainage. The wound was 90% pink-reddish and 10% subcutaneous tissue. The wound was assessed as a Stage 3 pressure ulcer. A review of the weekly skin assessment for 7/26/17 notes the resident sits in his chair most of the time and no skin condition noted. The subsequent weekly skin assessment dated 8/2/17 documents no skin conditions. A review of the skin assessment dated 8/9/17 notes resident is non-compliant with heel protectors and stays up in the wheelchair for long periods. The assessment also documents two skin conditions, the right leg (8/6/17) and the left leg which was first noted on 8/1/17.	4 136		

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4 136	Continued From page 13 A review of the Minimum Data Set (MDS) for significant change with an assessment reference date of 8/18/17 documents in Section M. Skin Conditions, Resident #3 was coded with one unhealed Stage 3 pressure ulcer. Resident #3 was also coded with functional limitation in range of motion on one side of the upper extremities and bilaterally to the lower extremities. In Section G. Functional Status, Resident #3 is noted to require extensive assistance with one person physical assist for bed mobility (how the resident moves to and from lying position, turns side to side and positions body while in bed or alternate sleep furniture). A review of the care plan found a focus for actual impaired skin integrity, fungal rash to groin, denudement to scrotum and left lateral upper thigh. Also noted the following: 4/22/17 Stage II right heel pressure injury; 5/19/17 Stage II right heel pressure injury now deep tissue injury; 6/27/17 right heel deep tissue injury healed; and 8/9/17 Stage 3 pressure injury right posterior lower extremity. Interventions included: referral to therapy as appropriate; cleanse right lower extremity wound with normal saline, apply bacitracin ointment, apply dry gauze, wrap with kerilix daily; juven 2 packets daily unit pressure ulcer is healed; document compliance an/or adherent to wound care regimen; assess for pain using 0-10 rating on numerical pain scale or by noting non-verbal cues every shift with wound care; administer pain medication as ordered; monitor site of impairment for signs and symptoms of infection such as swelling erythema, increased drainage and pain during each treatment; apply pillows under calves to off load heels while in bed; and monitor effectiveness of treatment. There was no documentation of an	4 136		

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4 136	Continued From page 14 interventions to address prevention of further skin impairment to the right lower extremity. Further review found care plans to address mobility deficit related to stroke and activities of daily living self-care performance. Interventions include: using a hoyer lift for transfers; therapeutic exercise; recommend rolling schedule with patient in bed to prevent bed sores with two person transfer with hoyer lift; restorative upper extremity range of motion program (passive range of motion to left upper extremity and a resting hand splint. The review of the kardex/task section in the electronic medical record included a list of tasks for the aides to perform. The tasks included: restorative nursing aide to perform lower body program 2-3 times a week to start on 10/14/16 for passive range of motion to include bilateral lower extremity, hip extension/flexion/abducter/adducter, bilateral knee extension and bilateral ankle dorsiflexion/extension with focus on passive range of motion for right knee extension with gentle stretching. A review of the last 30 days found documentation on 8/18/17 that the restorative nursing program was performed. On 9/14/17 at 9:30 A.M. an interview and concurrent record review was done with Staff Member #87 (Wound Consultant). Staff Member #87 reported Resident #3's pressure injury was related to crossing his legs while sitting in the wheelchair, the shin bone pressing on the back of the resident's posterior leg. The staff member also reported the resident is not always compliant with repositioning. Further queried the staff member whether the weekly skin assessment would identify pre-existing signs of a skin	4 136		

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4 136	Continued From page 15 breakdown as upon discovery of the wound, it was already assessed as a Stage 3 pressure ulcer. The staff member reported the signs of a skin break down if assessed early would prevent the advancement to Stage 3. The signs of the breakdown would include redness and advance to an open area, Stage 2 (affecting the first two layers). The staff member also identified skin impairment is more difficult to detect on fatty areas as opposed to bony areas. A review of the kardex/task section in the electronic medical record was done with Staff Member #3. The staff member confirmed the inclusion of the restorative nursing program. The staff member also confirmed a review of the last 30 days found documentation restorative nursing program was performed on 8/18/17. The staff member was asked whether the restorative nursing program would assist in the prevention of a pressure ulcer, the staff member replied a restorative nursing program would help in the prevention of a skin breakdown and for Resident #3 the passive range of motion would help to relieve the pressure and his muscles would not be so tight. A request was made to Staff Member #3 to provide documentation of the restorative nursing program for the last three months. On 9/14/17 at 3:35 P.M. the facility provided a copy of the task grid for June 2017 through September 2017 which documents when the restorative nursing program was done. A review of the documentation found the restorative nursing program was performed on 6/14/17; 7/7/17, 7/11/17, 8/3/17, 8/4/17 and 8/18/17. On 9/14/17 at 12:50 P.M. further review and interview was done with Staff Member #87.	4 136		

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4 136	Continued From page 16 Queried whether Resident #3's care plan was revised based on an assessment to identify possible contributing factors leading to the resident's identified pressure ulcer on 8/9/17. The staff member confirmed the care plan was not revised to include interventions to prevent further pressure related injuries. At this time the staff member added the following "position resident with use of pressure reducing devices (i.e. pillows, wedges) to prevent further pressure injury" to Resident #3's care plan. The facility failed to accurately perform a weekly skin assessment to identify the early stages of a skin breakdown which eventually was identified as a Stage 3 pressure ulcer acquired in the facility. The skin assessments done on 7/26/17 and 8/2/17 documents no skin conditions. On 8/6/17 Resident #3 is noted with a wound and subsequently assessed as a Stage 3 ulcer. The facility also failed to implement the resident's restorative nursing program as evidenced by the documentation provided by the facility. The restorative nursing program was documented to be done two to three times a week and over a period of three months, it was done six times. Subsequently, the facility did not revise the resident's care plan based on the identified causal factors that contributed to the Stage 3 pressure ulcer to the right lower posterior leg for prevention of another skin breakdown. 5) On 09/12/2017 at 10:08 AM, observed R#103 awake in bed with old metal SRs with peeling paint and rust showing. The SRs were shaky with space between the SRs and mattress for limb entrapment. On 09/13/2017 at 3:09 PM interviewed Staff# 22 and #79 and shared FDA.gov website for SR	4 136		

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4 136	Continued From page 17 safety and resident assessment guidelines. Both staff member went to R#103 bedside and observed resident in bed with SRs up and demonstrated to them how the SRs were shaky and with rust spots. On 09/14/2017 at 9:33 AM , EMR on R#103 found under the, "Orders" tab: "DME: wheelchair, jay prevention cushion, bilateral elevating leg rests, brake extension and buckle seat belt, semi electric hospital bed with half siderail." The quarterly Fall Risk Assessment dated 8/3/2017, documented that R#103 was at moderate risk with a score of 7.0. The "Rehab Services Screening" done 7/28/2017 noted, "No skilled intervention at this time for ST/OT/PT." The resident required total assist for functional mobility with wheelchair and extensive assistance for activities of daily living (ADLs). The resident was alert and oriented to person, time and place. The quarterly "Side Rail/Device Assessment" done 8/3/2017 for type of bed side rail, documented that R#103 used bilateral half side rails. The SRs were to assist the resident with bed positioning and mobility and daily care (holding of SR). The SR assessment was primarily to determine whether the SRs were a restraint or not as it noted, "The bed side rail is not a restraint because the resident can move in bed, but can't get out of bed on his own. Final Determination Side rails and/or other device are NOT a restraint." 6) On 09/12/2017 at 10:14 AM during Stage 1 of the survey, observed that R#5 was lying in bed with bilateral half old metal type side rails (SRs). The SRs were shaky and there was space between the SRs and mattress.	4 136		

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4 136	Continued From page 18 On 09/13/2017 at 3:09 PM interviewed Staff# 22 and #79 and shared FDA.gov website for SR safety and resident assessment guidelines. Both staff member went to R#5 bedside and observed resident in bed with SRs up and demonstrated to them how the SRs were shaky and with space between the SRs and mattress for limb entrapment. On 09/14/2017 at 10:28 AM observed R#5 lying prone and apparently sleeping; there were no SRs and the bed was at the normal height. On 09/14/2017 at 10:30 AM review of R#5's EMR found that the Side Rail/Device Assessment was done quarterly with the last dated 7/10/2017 and documented: "Type of Bed Side Rail: half rail top right; half rail top left; Bed side rails assist the resident with bed positioning and mobility; Daily Care (holding of SR); time of day and circumstances when device will be used,: When in bed; The bed side rail is not a restraint because the : Res can't move, so the bed rails are not restraining her; Final determination : Side rails and/or Other Device are NOT a restraint," The care plan (CP): "Potential for falls or fall related injuries related to generalized weakness, impaired sitting/standing balance, use of psychotropic medication with its possible adverse reaction; diagnosis of seizure disorder." CP interventions included: "...Keep bed in low position with brakes on at all times; For resident who are utilizing bilateral half rails for mobility and transfers, keep upper half rails up; Pad side rails as indicated to prevent injury during episode of seizure activity; Observe for possible occurrence of seizure like staring into space, tremors or shakiness; Take note of duration of seizure	4 136		

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4 136	Continued From page 19 activity and notify MD when seizure activity occur..." On 09/14/2017 at 1:27 PM observed R#5 lying prone in bed with Staff#107 finished taking vital signs. Queried Staff#107 if resident's bed in lowest position. Staff#107 used bed controls at foot of bed, lowered bed, and then stated this is the lowest position. When queried Staff#107 whether R#5's bed should be in low position, she replied, they all should be at lowest position. On 09/14/2017 at 1:52 PM discussed with Staff#79 bed rail assessment for R#5. According to Staff#79, the resident's SRs were removed because the resident was assessed and cannot move. Queried whether the staff looked at R#5's CP before removing SRs to ensure resident's safety. Staff#79 conferred with Staff#76 and inquired of her if SRs removed and assessment done. Staff#76 stated that she didn't make that decision to not use SRs because didn't contact family yet. Informed staff that according to the resident's CP, padded SRs are required due to a seizure disorder with bed lowered. Staff#79 stated that she was unaware because inquired of CNAs whether the resident moved around in bed, and assessed that resident cannot move. The facility failed to implement a system that address resident's risk in use of old metal SRs to minimize the likelihood of accidental limb entrapment. The facility also did not properly evaluate and analyze R#5's use of SRs to develop targeted interventions to reduce the potential for accidents. 7) On 09/12/2017 at 1:10 PM observed R#73 smoking in the facility's parking lot. The resident stated that she bought pack of cigarettes last	4 136		

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4 136	Continued From page 20 month and still had 10 cigarettes left. The resident further stated that she feeds the birds outside in the parking lot, and that she doesn't always smoke because trying to "cut down." On 09/13/2017 at 12:30 PM the EMR for R#73 noted on the CP: "The resident is at risk for noncompliance with smoking (past history of smoking), was witnessed smoking outside with other residents;" the goal was for the resident not suffer injury from unsafe smoking practices through the review date. The CP interventions included: "11/23/16 Resident signed Risks vs Benefits form; Instruct resident about smoking risks and hazards and about smoking cessation aids that are available; Instruct resident about the facility policy on smoking: locations, times, safety concerns." On 09/13/2017 at 12:43 PM interviewed Staff#79 and shared observations of R#73 smoking at designated smoking area that was not wheelchair accessible due to concrete curbing of parking lot. The resident was sitting in her wheel chair smoking in the parking lot where vehicles enter and exit. Staff#79 stated that she would discuss with Staff#22 about inaccessible designated smoking area. According to Staff#79, R#5 is A/O x 4 and able to make needs known. The Smoking policy was provided to the resident and she was also assessed for smoking safety. The resident had a BIMS score of 15. On 09/13/2017 at 1:00 PM, Staff#79 reported that she spoke with Staff#22 and the plan is to make the designated smoking area wheel chair accessible. During the construction period, the 3 smoking residents that use a wheel chair will be supervised to a wheel chair accessible smoking area.	4 136		

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4 136	Continued From page 21 On 09/13/2017 at 2:16 PM, Staff#108 stated that a concrete slab at the designated smoking area was being planned to make area wheelchair accessible. According to Staff#108, concrete curbing would have to be removed and will start pricing with contractors to complete task. The facility failed to implement a system to address resident's risk and environmental hazards for wheel chair bound residents to smoke in designated smoking area. 8) Resident #165 was admitted to the facility on 6/22/17 with diagnoses which included septicemia, thyroid disorder, anxiety disorder and morbid obesity. Resident #165 was a patient at the sister hospital of the long term care facility. Upon admission to the hospital, Resident #165 weighed more than 500 pounds. Upon admission to the long term care facility, Resident #165 weighed 445 pounds. On 7/17/17, Resident #165 weighed 429 pounds or 4% loss since admission. On 8/14/17, Resident #165 weighed 383 pounds or 14% since admission to the long term care facility. On the Resident Assessment Instrument (RAI), Resident #165 was coded as a nutrition risk due to her dramatic weight loss since admission. An observation of Resident #165 on the morning of 9/12/17 at 10:00 A.M. found her lying in bed watching TV. She stated that she's made several requests for food preferences but the kitchen continues to send the wrong foods. An observation of Resident #165 on the morning of 9/13/17 at 11:30 A.M. found her lunch tray untouched on the bedside table. The resident reported she wasn't feeling hungry.	4 136		

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4 136	Continued From page 22 A review of Resident #165's medical record found a physician's order dated 6/22/17 noting regular diet with regular texture and thin liquids consistency. On 7/11/17, the physician ordered, "Physician prescribed weight loss." The "Physician prescribed weight loss" order did not provide details on Resident #165's planned weight loss program. A review of Resident #165's care plan found, "(6/22/17) Nutritional risk related to Body Mass Index (BMI) too high (morbidly obese)". The goals included, "Resident's weight will remain stable or minus up to or >10% over 180 days through review date 9/2017"; and "Resident's weight will remain stable or minus up to or >5% over 30 days through review date 9/2017". Interventions included: "Encourage resident to consume all meals and provide assistance as needed; Notify MD if any changes in condition e.g. poor oral intake, significant weight loss." The care plan was not consistent with the "Physician prescribed weight loss". Additionally, the facility did not provide details of a safe, monitored, and paced weight loss for Resident #165. The physicians orders and care plan did not describe a goal weight for Resident #165. A review of the Dietician's notes on the morning of 9/13/17 at 10:00 A.M. found a note dated 7/10/17 which stated, "BMI >35: MD Please order 'physician prescribed weight loss' to allow significant weight loss to be correctly coded in section K of the MDS document." An interview of the Registered Dietician (RD) on the afternoon of 9/14/17 at 1:45 P.M. revealed her recollection that Resident #165 was on a physician prescribed weight loss plan due to morbid obesity. The RD did not provide details of the weight loss plan. The facility failed to utilize an appropriate care	4 136		

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4 136	Continued From page 23 plan for a safe physician prescribed weight loss plan for Resident #165. The care plan contradicted the goal of weight loss. Additionally, the facility failed to identify a safe, effective weight loss plan that would be monitored and evaluated as the resident slowly and gradually lost weight. 9) Resident #188 was admitted to the facility on 8/24/17 with diagnoses which included Coronary Artery Disease; Hypertension; and Depression. The resident was a patient at the facility's sister hospital prior to admission. A review of the RD's notes found a note dated 8/31/17 which noted Resident #188 experienced a 5% weight loss since his admission to the hospital. The RD noted Resident #188 had a BMI >35 and noted, "MD please order 'Physician prescribed weight loss' to allow significant weight loss to be correctly coded in Section K of the MDS document." The RD note dated 9/13/17 found, "Resident [#188] had a 3% weight loss over the past 30 days - physician prescribed weight loss ordered". However, on the morning of 9/14/17 at 10:00 A.M., a review of the physician's orders for Resident #188 did not find orders for a "physician's prescribed weight loss program". An interview of the RD on the afternoon of 9/14/17 at 1:48 P.M. found the RD was unaware that the "nursing staff did not follow through on her recommendation for a physician prescribed weight loss program". She further stated she thought it has been ordered and admitted that it was her responsibility to ensure the order was in place. A care plan review for Resident #188 found a "Nutritional Risk" care plan with interventions	4 136		

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4 136	Continued From page 24 which included: "Encourage resident to consume all meals and provide assistance as needed; Notify MD of any changes in condition e.g. poor oral intake, significant weight loss; Offer and provide alternatives for meal consumption less than 50%". Resident #188's "Nutritional Risk" care plan further noted the following goals: Resident's weight will remain stable or minus up to or >5% over 30 days through review date 12/2017; and Resident's weight will remain stable or minus up to or >10% over 180 days through review date 12/2017. The goals and interventions included in Resident #188's care plan were inconsistent with the "Physician prescribed weight loss program". Additionally, the care plan failed to address the a safe, monitored, and paced weight loss for Resident #188. The facility failed to utilize an appropriate care plan for a safe physician prescribed weight loss plan for Resident #188. Resident #188's care plan contradicted the goal of weight loss. Additionally, the facility failed to identify a safe, effective weight loss plan that would be monitored and evaluated as the resident slowly and gradually lost weight. In conclusion, the facility failed to provide clear and specific goals and interventions for physician prescribed weight loss programs for both Resident #165 and Resident #188.	4 136		
4 173	11-94.1-43(a) Interdisciplinary care process (a) A comprehensive assessment shall be completed for each resident by an interdisciplinary team at least annually and updated as appropriate, based on the resident's condition.	4 173		

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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
4 173	Continued From page 25	4 173		

This Statute is not met as evidenced by:
Based on observations, staff interviews and medical record reviews (MRR), the facility failed to ensure that 2 of 21 residents (R#5 and R#73) on the Stage 2 Resident Sample list, were comprehensively assessed as part of an ongoing process through which the facility identifies the resident's functional capacity and health status.

Findings include:

1) Cross to §11-94.1-30. On 09/12/2017 at 10:14 AM during Stage 1 of the survey, observed that R#5 was lying in bed with bilateral half old metal type side rails (SRs). The SRs were shaky and there was space between the SRs and mattress.

On 09/13/2017 at 3:11 PM,discussed with Staff#22 and Staff#79 of SRs and resident safety to prevent entrapment, and shared FDA.gov website on bed rail safety to show examples. Both staff members accompanied surveyor to R#5's room to look at the SRs, and the resident was lying prone in bed with the SRs up.

On 09/14/2017 at 10:28 AM observed R#5 lying prone and apparently sleeping; there were no SRs and the bed was at the normal height.

On 09/14/2017 at 10:30 AM review of R#5's EMR found that the Side Rail/Device Assessment was done quarterly with the last dated 7/10/2017 and documented: "Type of Bed Side Rail: half rail top right; half rail top left; Bed side rails assist the resident with bed positioning and mobility; Daily Care (holding of SR); time of day and

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	125015	A. BUILDING: _____ B. WING _____	09/15/2017

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4 173	Continued From page 26 circumstances when device will be used,: When in bed; The bed side rail is not a restraint because the : Res can't move, so the bed rails are not restraining her; Final determination : Side rails and/or Other Device are NOT a restraint," The care plan (CP): "Potential for falls or fall related injuries related to generalized weakness, impaired sitting/standing balance, use of psychotropic medication with its possible adverse reaction; diagnosis of seizure disorder." CP interventions included: "...Keep bed in low position with brakes on at all times; For resident who are utilizing bilateral half rails for mobility and transfers, keep upper half rails up; Pad side rails as indicated to prevent injury during episode of seizure activity; Observe for possible occurrence of seizure like staring into space, tremors or shakiness; Take note of duration of seizure activity and notify MD when seizure activity occur..." On 09/14/2017 at 1:27 PM observed R#5 lying prone in bed with Staff#107 finished taking vital signs. Queried Staff#107 if resident's bed in lowest position. Staff#107 used bed controls at foot of bed, lowered bed, and then stated this is the lowest position. When queried Staff#107 whether R#5's bed should be in low position, she replied, they all should be at lowest position. On 09/14/2017 at 1:52 PM discussed with Staff#79 bed rail assessment for R#5. According to Staff#79, the resident's SRs were removed because the resident was assessed and cannot move. Queried whether the staff looked at R#5's CP before removing SRs to ensure resident's safety. Staff#79 conferred with Staff#76 and inquired of her if SRs removed and assessment done. Staff#76 stated that she didn't make that	4 173		

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4 173	Continued From page 27 decision to not use SRs because didn't contact family yet. Informed staff that according to the resident's CP, padded SRs are required due to a seizure disorder with bed lowered. Staff#79 stated that she was unaware because inquired of CNAs whether the resident moved around in bed, and assessed that resident cannot move. Staff#79 stated that R#5 has history of seizure but had no seizures in the facility since admitted in 01/2015. Discussed that the last IDT meeting on 7/13/2017 and CP documented SRs with diagnosis of seizure disorder. The current CP did not reflect IDT meeting decisions on 7/13/17 on whether padded SRs still relevant for the resident. 2) On 09/12/2017 at 1:10 PM observed R#73 smoking in the facility's parking lot. The resident stated that she bought pack of cigarettes last month and still had 10 cigarettes left. The resident further stated that she feeds the birds outside in the parking lot, and that she doesn't always smoke because trying to "cut down." On 09/13/2017 at 12:30 PM the EMR for R#73 noted on the CP: "The resident is at risk for noncompliance with smoking (past history of smoking), was witnessed smoking outside with other residents;" the goal was for the resident not suffer injury from unsafe smoking practices through the review date. The CP interventions included: "11/23/16 Resident signed Risks vs Benefits form; Instruct resident about smoking risks and hazards and about smoking cessation aids that are available; Instruct resident about the facility policy on smoking: locations, times, safety concerns." On 09/13/2017 at 12:43 PM interviewed Staff#79	4 173		

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4 173	Continued From page 28 and shared observations of R#73 smoking at designated smoking area that was not wheelchair accessible due to concrete curbing of parking lot. The resident was sitting in her wheel chair smoking in the parking lot where vehicles enter and exit. Staff#79 stated that she would discuss with Staff#22 about inaccessible designated smoking area. According to Staff#79, R#5 is A/O x 4 and able to make needs known. The Smoking policy was provided to the resident and she was also assessed for smoking safety. The resident had a BIMS score of 15. On 09/13/2017 at 1:00 PM, Staff#79 reported that she spoke with Staff#22 and the plan is to make the designated smoking area wheel chair accessible. During the construction period, the 3 smoking residents that use a wheel chair will be supervised to a wheel chair accessible smoking area. On 09/13/2017 at 2:16 PM, Staff#108 stated that a concrete slab at the designated smoking area was being planned to make area wheelchair accessible. According to Staff#108, concrete curbing would have to be removed and will start pricing with contractors to complete task. The facility failed to address all needs and strengths of residents whether the issue is included in the MDS or CAAs.	4 173		
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,	4 174		

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4 174	Continued From page 29 dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on record review and interview with facility staff, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 13 sampled residents (Resident #76) of 27 residents in the Stage 2 sample. Findings include: Cross Reference to §11-94.1-30. Resident #76 was admitted on 12/02/16 to the facility with diagnoses including: Diabetes Mellitus type 2, diabetic neuropathy, primary hypertension, transient ischemic attack and cerebral infarction without residual deficits. On 9/14/17 at 12:30 P.M. a review of the quarterly Minimum Data Set (MDS)with assessment reference dates of 5/26/17 and 8/18/17, Resident #76 yielded a score of 2; moderately impaired-limited vision, not able to see newspaper headlines but can identify objects and not having corrective lenses. On 9/14/17 at 2:40 P.M. Resident #76's care plan was reviewed indicating there were no goals or interventions to address the vision deficit documented in the quarterly assessments. At 1:48 P.M. during an interview with Staff #2, when asked if Resident #76 was able to see, Staff #2 responded that Resident #76 can't see very well and could benefit from the use of glasses. At the request of the surveyor, Staff #76 reviewed the Electronic Medical Record and stated there was no Ophthalmology consultation for Resident #76	4 174		

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4 174	Continued From page 30 for a vision exam. At 1:52 P.M. the MDS Coordinator reviewed the care plan and concurred with Staff #2 that there is nothing written in the care plan to address the vision deficit. Staff #67 stated that the care plan will be updated and the family contacted to assist the resident with an eye exam and to obtain glasses. The facility failed to provide necessary care and services to attain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	4 174		
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on observations, staff and resident interviews, and medical record reviews, the facility failed to ensure that 3 of 21 residents (R#103, R#73 and R#3) overall plan of care was reviewed and revised based on the resident's condition. Findings include: 1) Based on F441, R#103 continued to place his urinal on the overbed table and the CP: "Impaired ADLs/Mobility R/T: generalized weakness associated with exacerbation of CHF, HTN, A-fib, Vit D deficiency, Gout, and hx of	4 175		

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4 175	Continued From page 31 CVA-L sided hemiplegias/paresis; M/B: res requiring ext to total asst in ADL functions. Non-ambulatory. w/c primary mode of locomotion. bedfast per preference." The CP further documented that, "Prior level of function was independent with the use of cane to ambulate as reported by resident; Strengths: alert and oriented to name, place and times as well as situation; able to make his needs known." "Note: refuses to get out of bed to sit up in w/c and to transfer during shower days thus bed bath provided." The goals were that the resident would maintain level of ADL performance from extensive asst in most areas like bed mobility, personal hygiene, toilet use, dressing, bathing through next review." The resident preferred to keep his urinal on the overbed table next to his water pitcher and had meals served on overbed table as well. The facility did not explore other options for R#103 to keep his urinal in a sanitary manner that was separate from a clean area for eating and drinking. 2) Based on F309, R#73 CP was not revised to reflect that hemodialyis (HD) was on Mon, Wed, Fri. from 4:45-8:30 PM. On 09/15/2017 at 9:34 AM, MRR on R#73 found that a, "Risks v. Benefits" form was signed by the resident on 10/10/14 and witnessed. On this form for "area of concern" was regarding food and resident's occasional refusal to go to dialysis. Besides changing the days and times for dialysis, there were no documentation on whether the facility explored other alternatives to accommodate both the exercise of the resident's rights and the resident's health.	4 175		

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4 175	Continued From page 32 3) Cross Reference to F314. Based on an assessment, the facility failed to revise Resident #3's care plan to develop interventions to prevent further skin breakdown following the presence of a Stage 3 pressure ulcer to the lower posterior of the right leg. The staff member reported the resident's skin breakdown was related to crossing of his legs while seated in the wheelchair. However, there was no intervention identified to address this issue. The staff member added the intervention to the resident's care plan during the survey.	4 175		
4 203	11-94.1-53(a) Infection control (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 observations and staff interviews, the facility failed to ensure that infection prevention practices are followed for the use of a urinal at the bed side for 1 of 21 residents (R#103) on the Stage 2 Sample Resident List. Findings include: On 09/14/2017 at 10:18 AM observed R#103 sleeping in bed and urinal filled with urine on overbed table. On 09/14/2017 at 1:31 PM observed R#103 in bed watching TV, urinal with urine on overbed	4 203		

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4 203	Continued From page 33 table. Queried resident if staff didn't empty urinal from that morning and he replied that urinated in urinal just little while ago. Queried whether resident was instructed to keep urinal on overbed table next to water pitcher and where ate his meals. R#103 stated that urinal should be hung from side rail (SR) but he had difficulty reaching for urinal if placed on SR. On 09/14/2017 at 1:46 PM interviewed Staff#33 regarding R#103 filled urinal on overbed table. According to Staff#33, the resident's urinal is emptied before breakfast, lunch and in the afternoon before 3 PM. The resident preferred to keep urinal on overbed table even though told to hang it from the SR. R#103 didn't use call-light for staff to empty the urinal, so staff had to check. R#103 was considered A/Ox4 and able to make needs known. The nurses also knew of this behavior, but the resident preferred that urinal stay on his right (R) side next to the water pitcher. On 09/15/2017 at 12:09 PM the electronic medical record (EMR) found that R#103 diagnoses included cardiovascular accident (CVA) with left sided hemiparesis. On the care plan (CP), "Impaired ADLs/Mobility related to generalized weakness associated with exacerbation of CHF, HTN, A-fib, Vit D deficiency, Gout, and hx of CVA-L sided hemiplegias/paresis," it was noted, "refuses to get out of bed to sit up in wheel chair (w/c), and to transfer during shower days thus bed bath provided." The CP interventions included, "RNA program for maintenance 3-5x week revisit resident when he refuses RNA program and explain the risk for being steadfast." According to Staff#71, the EMR task bar tab for bladder continence/toilet use documented the	4 203		

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4 203	Continued From page 34 times that the urinal was emptied. From 09/11-13/2017, the urinal was emptied 6-8 times a day and at various times of day. The annual minimum data set (MDS) 3.0 for R#103 dated 5/16/17 documented that the resident required extensive assistance with 1 person physical assistance when using the toilet, moving in bed, dressing and performing personal hygiene. The resident was coded for functional limitation in range of motion in the lower extremity (hip, knee, ankle, foot; with impairment on both sides. The facility did not follow standard precautions for infection prevention practices by continuing to allow the resident to store his urinal after use on the same overbed table where meals were served and eaten, and placed right next to his water pitcher.	4 203		

Wahiawa General Hospital-LTC
128 Lehua Street
Wahiawa, Hawaii 96786

September 15, 2017 Plan of Corrections (PoC) STATE

ID Prefix Tag	Responsible Party	Provider's Plan of Corrective Action	Completion Date
4 125 11-94.1-27(14) Resident rights and facility practice	Social Services, Nursing	Social Worker spoke to Resident #46 and assessed resident's privacy curtain. Curtain is long enough to provide privacy around resident's bed. Staff Education regarding privacy completed. Complete a full facility audit to ensure all resident curtains are long enough to provide privacy. All residents have the potential to be affected by the deficient practice. Revise current Privacy Tool to include rounds with a random sample of 10% of residents. Privacy rounds to be completed monthly. Results of this audit will be reported in the Quarterly QAPI Committee meeting for one year and thereafter as determined by the committee.	**9/18/17** **9/18/17, 10/26/17 & 10/27/17** **11/10/17** **11/10/17 & Ongoing**
4 136 11-94.1-30 Resident Care	Director of Nursing, Assistant DON, Long Term Care Coordinator, RN Team Leader, CNA, Social Worker, MDS, Dietician, Facilities	24/7 1:1 caregiver assigned to Resident #38. DOH AMHD Medical Director contacted for counsel and feedback. DOH AMHD Medical Director stated that there is no appropriate facility for this resident in the State of Hawaii at this time. Director stated that DOH and DHS are in the "talking" stages of funding such a facility but it will not be available for another 2 years. Staff education on how to manage difficult patients to be arranged. All residents who exhibit assaultive and violent behavior pose a danger to staff and other residents. Staff instructed and in-serviced on a Safety Plan for Resident which includes, but not limited to, the following: When resident exhibits danger to self and/or others, police will be contacted via 911 and dispatcher informed it is urgent. Charges for assaultive behavior will be filed with HPD, with the intention of transferring resident to a more appropriate setting which can address the assaultive and aggressive behaviors. File a Temporary Restraining Order in the event that resident becomes a danger to others. Family, Administrator, MD, DON, ADON, SW to be notified	**9/14/17** **10/10/17** **11/10/17** **9/15/17 & Ongoing**

11-9-17 KW recvd. via email from facility; pr

		of any incident in which police are called. Staff will continue to monitor resident's behaviors, as well as document resident's behavior and incidents promptly and accurately. MD will modify medications as needed. Case managers of Medicaid provider will be consulted for feedback in providing psychiatric interventions. Report progress of resident's behavior and safety plan at the quarterly QAPI Committee meeting for one year and thereafter as determined by the committee. List of all residents receiving HD treatments compiled. Revised HD Assessment to indicate specificity of the fistula site. Education provided to LN's regarding the new assessment. Spoke with LPN regarding incorrect documentation. All residents receiving HD treatments have the potential to be affected by the deficient practice. LTCC will monitor the completion and accuracy of the HD assessment on a weekly basis. Results to be reported in quarterly QAPI Committee meeting for one year and thereafter as determined by the committee	
		List of all residents receiving HD treatments compiled. Revised HD Assessment to indicate specificity of the fistula site. Education provided to LN's regarding the new assessment. Spoke with LPN regarding incorrect documentation. All residents receiving HD treatments have the potential to be affected by the deficient practice.	**10/12/17**
		LTCC will monitor the completion and accuracy of the HD assessment on a weekly basis. Results to be reported in quarterly QAPI Committee meeting for one year and thereafter as determined by the committee.	**10/12/17 & Ongoing**
		Daughter of Resident #76 declined EENT consult and expressed no interest in obtaining a corrective device. Resident has not used eyeglasses for 1 1/2 years. Care plan updated. All residents have the potential to be affected by the deficient practice.	**10/11/17**
		Nurse will continue to explore with resident/family their interest on use of corrective glasses or visual devices on a quarterly basis. Coordinate with family/resident for referral to EENT as needed to enhance visual function. Nurse will address visual limitation, reason for no corrective glasses/visual device, and intervention in the care plan	**10/1/17 & Ongoing**

		quarterly and as needed. Nurse will utilize MDS/IDT care plan schedule to ensure all residents with visual impairment are addressed in the plan of care.	
		Revision of IDT summary form to include visual impairment. Develop a separate care plan for Visual Impairment in the E.H.R.	**10/31/17**
		MDS Assistant to review all survey sampled residents with visual impairment and update care plans as appropriate. All other residents will be addressed as they come up for quarterly review.	**11/10/17 & Ongoing**
		Report data of the audit for visual impairment on a quarterly basis at the QAPI Committee meeting for one year and thereafter as determined by the committee.	
		New skin assessment completed for Resident #3. Resident signed risk vs. benefits form for noncompliance with treatment plan for pressure ulcer prevention.	**9/15/17**
		Reviewed and updated care plan.	**9/18/17**
		LN's educated on Head to Toe Skin assessments and completion of Skin Assessment form.	**10/3/17**
		Transfers for resident changed back to use of the hoyer lift.	**10/5/17**
		PT evaluation for UE/LE contractures/positioning completed.	**8/16/17 & 10/7/17**
		CNA staff education on Task portion of the EHR which includes skin.	**10/26/17 & 10/27/17**
		All residents have the potential to be affected by the deficient practice.	
		LTCC/ADON to monitor current wounds in house every Wednesday. Pressure Ulcer Prevention Program (PUP) re-implemented. This will include monthly education materials and in-services for staff every quarter. Program will include a weekly list of current pressure injuries. Rehab Department to be consulted for any residents with contractures as needed.	**10/18/17 & Ongoing**
		Revise Policy and Procedure for PUP.	**11/10/17**
		ADON, or Designee, to track Weekly Skin Assessment and EHR Tasks for completion and accuracy for residents with current skin issues. LTCC to monitor PUP and report findings from both audits in the quarterly QAPI Committee meeting for one year and thereafter as determined by the committee.	
		Resident #103 was issued another bed without rusty bed rails.	**11/3/17**

		Resident #5's care plan was updated, bed rails were raised, and padding added. CNA's were reminded to lift rails back up after brief change or ADL care if lowered.	**9/15/17**
		Compiled a current list of all residents with Seizure Disorder and completed a new bed rail assessment, including Resident #5.	**10/3/17**
		All residents with Seizure Disorder have the potential to be affected by the deficient practice.	
		Quarterly audit of all residents with Seizure Disorders at the Quarterly IDT meetings to ensure care plans and bed rail assessments are accurate.	**10/31/17**
		Revise IDT form to include Seizure Disorder, care plans, and bed rail assessments.	
		Results of audit to be reported at the quarterly QAPI Committee meeting for one year and thereafter as determined by the committee.	
		Full facility audit to review and assess all residents' beds, bed rails, risk and entrapment hazards, mattress size, and bed condition to be completed. Depending on assessment, residents were either issued another bed, one or both rails were strapped down, or current bed was altered to meet immediate compliance.	**10/13/17 & 11/3/17**
		All residents have the potential to be affected by the deficient practice.	
		Bed rail assessments and care plans will be revised based on implemented changes following the audit. Monthly audit on all mattresses and beds to ensure compliance utilizing a tracking tool.	**10/13/17 & Ongoing**
		Bed Compliance Project initiated. Program includes completion of a second assessment of all WNRC beds/mattresses, ordering of safety assist bars for installation in place of side rails to assist residents with bed mobility and transfers, and purchase new beds if select beds from facility wide assessment cannot be altered to meet compliance.	**10/24/17 & Ongoing**
		Results of the monthly audit to be reported in the quarterly QAPI meeting for one year and thereafter as determined by the committee. Progress of the WNRC Bed Compliance Project to be monitored in the monthly Project Management Steering Committee to ensure completion.	
		New smoking assessment completed for all residents who smoke including Resident #73. All smoking residents have a care plan in place. Residents were provided an alternative smoking area until such time the designated smoking area could be constructed to ensure safety.	**9/13/17**

		Assessment and proposal received for construction of the designated smoking area. An area measuring 18' x 18' will be paved and leveled with the road. The curb will be removed to allow for an accessible pathway onto the paved area. This will ensure residents are not sitting on the main parking lot roadway.	**9/26/17**
		Construction completed.	**10/20/17**
		All residents who smoke have the potential to be affected by the deficient practice.	
		Added Smoking Assessment and Care Plan to Admission Checklist. Monthly audit of all residents who smoke to ensure compliance. Monthly list of all residents who smoke will be provided on the first Monday of the month. Care plans will be updated at the Quarterly IDT meeting and as needed. Smoking assessments will be completed on a quarterly basis for residents who smoke to ensure they have an appropriate safety plan in place. Smoking assessment added to the M-F stand up meeting agenda to ensure daily discussion and monitoring.	**10/30/17 & Ongoing**
		Results of monthly audit to be reported at the quarterly QAPI Committee meeting for one year and thereafter as determined by the committee.	
		Physician prescribed weight loss orders were obtained for Resident #165 and Resident #188. Resident #165 currently continues with the weight loss order.	**7/11/17**
		Goals and weight loss program approaches are stated in dietary care plan and evaluation of weight loss progress is documented in the weekly Nutrition Risk progress notes. Care plan for Resident #165 was revised.	**9/14/17**
		Resident #188 had weight loss order discontinued because he was not meeting weight loss goals.	**11/6/17**
		Residents w/ BMI >35 will be identified at admission and quarterly in MDS nutrition assessment. Appropriateness of physician prescribed weight loss will be determined.	**9/27/17 & Ongoing**
		Residents identified as appropriate for the Physician Prescribed Weight Loss Program will be monitored weekly in the Nutrition Risk (NR) Committee for at least 4 weeks post admission. Further monitoring in the NR Committee will be determined by committee members.	
		Develop Physician Prescribed Weight Loss Care Plan in Point Click Care. Quarterly Nutrition assessments will be used to evaluate and document whether weight loss goals are being met as described in the Physician Prescribed Weight Loss Dietary care plan for residents with physician prescribed weight loss orders. Google Docs spreadsheet audit will occur on the 1st, 4th, 7th and 10th months to document that residents with prescribed weight loss order	**11/2/17 & Ongoing**

		have an active order, process and goals are stated in care plan, and evaluation/monitoring of weight loss progress stated in quarterly Nutrition assessments. Policy and Procedure developed for Physician Prescribed Weight Loss Monitoring. Results of monitoring will be reported in the quarterly QAPI Committee meeting for one year and thereafter as determined by the committee.	
4 173 11-94.1-43(a) Interdisciplinary care process	Nursing, MDS, Administrator, Facilities	Resident #5's care plan was updated, bed rails were raised, and padding added. CNA's were reminded to lift rails back up after brief change or ADL care if lowered. Compiled a current list of all residents with Seizure Disorder and completed a new bed rail assessment, including Resident #5. All residents with Seizure Disorder have the potential to be affected by the deficient practice. Quarterly audit of all residents with Seizure Disorders at the Quarterly IDT meetings to ensure care plans and bed rail assessments are accurate. Revise IDT form to include Seizure Disorder, care plans, and bed rail assessments. Results of audit to be reported at the quarterly QAPI Committee meeting for one year and thereafter as determined by the committee. New smoking assessment completed for all residents who smoke including Resident #73. All smoking residents have a care plan in place. Residents were provided an alternative smoking area until such time the designated smoking area could be constructed to ensure safety. Assessment and proposal received for construction of the designated smoking area. An area measuring 18' x 18' will be paved and leveled with the road. The curb will be removed to allow for an accessible pathway onto the paved area. This will ensure residents are not sitting on the main parking lot roadway. Construction completed. All residents who smoke have the potential to be affected by the deficient practice. Added Smoking Assessment and Care Plan to Admission Checklist. Monthly audit of all residents who smoke to ensure compliance. Monthly list of all residents who smoke will be provided on the first Monday of the month. Care	**9/15/17** **10/3/17** **10/20/17 & Ongoing** **11/3/17** **9/13/17** **9/26/17** **10/20/17** **10/30/17 & Ongoing**

		plans will be updated at the Quarterly IDT meeting and as needed. Smoking assessments will be completed on a quarterly basis for residents who smoke to ensure they have an appropriate safety plan in place. Smoking assessment added to the M-F stand up meeting agenda to ensure daily discussion and monitoring. Results of monthly audit to be reported at the quarterly QAPI Committee meeting for one year and thereafter as determined by the committee.	
4 174 11-94.1-43(b) Interdisciplinary care process	MDS, Long Term Care Coordinator	Daughter of Resident #76 declined EENT consult and expressed no interest in obtaining a corrective device. Resident has not used eyeglasses for 1 1/2 years. Care plan updated. All residents have the potential to be affected by the deficient practice. Nurse will continue to explore with resident/family their interest on use of corrective glasses or visual devices on a quarterly basis. Coordinate with family/resident for referral to EENT as needed to enhance visual function. Nurse will address visual limitation, reason for no corrective glasses/visual device, and intervention in the care plan quarterly and as needed. Nurse will utilize MDS/IDT care plan schedule to ensure all residents with visual impairment are addressed in the plan of care. Revision of IDT summary form to include visual impairment. Develop a separate care plan for Visual Impairment in the E.H.R. MDS Assistant to review all survey sampled residents with visual impairment and update care plans as appropriate. All other residents will be addressed as they come up for quarterly review. Report data of the audit for visual impairment on a quarterly basis at the QAPI Committee meeting for one year and thereafter as determined by the committee.	**10/11/17** **10/1/17 & Ongoing** **10/31/17** **11/10/17 & Ongoing**
4 175 11-94.1-43(c) Interdisciplinary care process	Facilities, Nursing, Administrator, Purchasing	Ordered a permanent large mattress for Resident #46. Contacted Hill-Rom to rent a larger bed and mattress for Resident #4 until such time the permanent mattress arrives. Resident updated about plan. Rental bed and mattress delivered. All residents who require a larger bed and mattress have the potential to be affected by the deficient practice. The screening list for the admissions process will be revised to include DME needs, such as larger beds or mattresses, to ensure the facility has the appropriate DME in place. Update admissions policy to include changes.	**10/5/17** **10/9/17** **10/10/17** **11/8/17** **11/10/17**

		Complete a full facility audit to evaluate beds and mattresses. Quarterly audit utilizing a tracking tool on all mattresses and beds to ensure compliance. Results of the quarterly audit will be reported in the quarterly QAPI Committee meeting for 6 months and thereafter as determined by the committee.	**10/13/17 & Ongoing**
		Resident #103 was given another table for his urinal. Urinal task was added to the E.H.R. to ensure resident's urinal is emptied on a regular basis. Identified all residents who are using urinals. Educated staff on Infection Prevention and placement of urinals. All residents who use urinals have the potential to be affect by the deficient practice. Staff to do rounding on a regular basis for all identified residents who use urinals to ensure that urinals are emptied and placed at the side of the bed in an appropriate place after each use. Point of Care Task added to the Point Click Care system to ensure urinals are emptied and rounds are done on a regular basis. Utilizing an audit tool, Nursing Supervisor, or designee, to check the tasks and provide a report to the DON or ADON every two weeks. Results of the tracking will be reported at the quarterly QAPI Committee meeting for one year and thereafter as determined by the committee.	**11/3/17** **11/3/17 & Ongoing**
		HD Care Plan revised for Resident #73. Other HD Care Plans revised and specific days removed for residents receiving HD treatments. Care plans modified to include number of times HD residents required to attend weekly, adding the term "as needed" for HD cases in which resident requires additional sessions. Social Worker met with resident to discuss her preferences regarding her HD schedule. Resident reported she was happy with it and that the changes are usually due to the HD Center or herself because of resident changing her mind on a frequent basis. Educate staff not to include specific days of the week in the care plan. All HD residents have the potential to be affected by the deficient practice. All HD care plans will now include number of days per week for HD treatments instead of specific days. Revise custom HD Care Plan to include change. Care plans will be monitored on a quarterly basis during IDT meetings to ensure no specific days are listed.	**10/5/17** **11/8/17** **10/26/17 & 10/27/17** **10/27/17 & Ongoing**

		Results to be reported at the quarterly QAPI Committee meeting for 6 months or thereafter as determined by the committee.	
		New skin assessment completed for Resident #3. Resident signed risk vs. benefits form for noncompliance with treatment plan for pressure ulcer prevention.	**9/15/17**
		Reviewed and updated care plan.	**9/18/17**
		LN's educated on Head to Toe Skin assessments and completion of Skin Assessment form.	**10/3/17**
		Transfers for resident changed back to use of the hoyer lift.	**10/5/17**
		PT evaluation for UE/LE contractures/positioning completed.	**8/16/17 & 10/7/17**
		CNA staff education on Task portion of the EHR which includes skin.	**10/26/17 & 10/27/17**
		All residents have the potential to be affected by the deficient practice.	
		LTCC/ADON to monitor current wounds in house every Wednesday. Pressure Ulcer Prevention Program (PUP) re-implemented. This will include monthly education materials and in-services for staff every quarter. Program will include a weekly list of current pressure injuries. Rehab Department to be consulted for any residents with contractures as needed.	**10/18/17 & Ongoing**
		Revise Policy and Procedure for PUP.	**11/10/17**
		ADON, or Designee, to track Weekly Skin Assessment and EHR Tasks for completion and accuracy for residents with current skin issues. LTCC to monitor PUP and report findings from both audits in the quarterly QAPI Committee meeting for one year and thereafter as determined by the committee.	
4 203 11-94.1-53 (a) Infection control	Long Term Care Coordinator, CNA, LPN/RN Team Leaders, Director of Nursing, Assistant Director of Nursing	Identified all residents who are using urinals. Educated staff on Infection Prevention and placement of urinals.	**10/3/17**
		All residents who use urinals have the potential to be affect by the deficient practice.	
		Staff to do rounding on a regular basis for all identified residents who use urinals to ensure that urinals are emptied and placed at the side of the bed in an appropriate place after each use. Point of Care Task added to the Point Click Care system to ensure urinals are emptied and rounds are done on a regular basis. Utilizing an audit tool, Nursing Supervisor, or designee, to check the tasks and provide a report to the DON or ADON on a monthly basis.	**10/10/17 & Ongoing**

		Results of the tracking will be reported at the quarterly QAPI Committee meeting for one year and thereafter as determined by the committee.	

Provider Signature:

Rebecca Canon-Fratis

Rebecca Canon-Fratis, NHA, LSW, MSW, MSG
Administrator- LTC

11/9/2017

Date