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
	125002	A. BUILDING: _____ B. WING _____	10/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILO MEDICAL CENTER	1190 WAIANUENUE AVENUE HILO, HI 96720

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4 000	Initial Comments The relicensing was conducted by the State Agency from October 16, 2017 to October 20, 2017. The facility's census included 29 residents upon entrance.	4 000		
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, staff interviews and Electronic Medical Record (EMR) reviews, the facility failed to ensure that 1 of 16 residents (R #31) on the Stage 2 Sample Resident List was provided care to promote healing, pain control and prevent infection due to an existing pressure ulcer (PU). Finding include: During an EMR review on 10/17/2017 at 08:31 AM R #31 was admitted with a Stage 4 pressure ulcer to the right buttock and hip. There were no orders for wound vac dressing changes three	4 136	**11-94.1-30 Resident Care** **Corrective action for residents affected:** Staff who did not perform proper wound care protocol was immediately made aware on 10/19/17. The wound nurse staff involved was re-educated regarding the findings by the Director of Nursing Services. **Identifying other residents having potential to be affected, and what corrective action will be taken:** Licensed staff have been re-educated on the Wound Care Protocol for Acute & Long Term Care (LTC) by the Director of Nursing Services	10/27/17

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

Marilyn Hanei | Administrator | 12/8/17.

2/15/17 - copy to SWJ bn

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4 136	Continued From page 1 times per week (Monday, Wednesday and Friday). During an interview on 10/18/2017 at 11:04 AM, Staff #2 stated that staff nurses do the daily wound care which includes the wound vac dressing changes. The wound nurse does weekly assessments once per week. Queried where wound nurse documentation would be located and Staff #2 looked at EMR under Notes but there was no wound nurse documentation for the once a week evaluation. Staff #2 explained that if wound healing, wound nurse wouldn't document because wound healing nicely. Pointed out documentation by Staff #47 written on 10/05/17 at 11:27 in Nurse Note, "wound Right butt: no overall improvement noted in R butt wound status. Per Staff #52, (Wound Nurse), obtain surgical consult for R butt wound." Documentation of the EMR revealed inconsistent information regarding the wound characteristics. The wound measurement flowsheet stated the wound had undermining which was at 2 cm; the wound length got larger. Staff #2 stated the inconsistency is probably due to different nurses measuring the wound. Staff #2 further stated that goals were the same, "maintain granulation tissue and get closer to surface then outside start to shrink." There was no infection, no redness or warmth around and no slough. Staff #47 documented "odiferous" on 10/16 and wound nurses both noted wound not "odiferous" during dressing change. On 10/19/2017 at 9:22 AM observed Wound nurses Staff #52 and #53 do dressing change to R #31's R buttock pressure wound. Staff #53 obtained wound dressing supplies and placed	4 136	**Identifying other residents having potential to be affected, and what corrective action will be taken:** Licensed staff have been re-educated on the Wound Care Protocol for Acute & Long Term Care (LTC) by the Director of Nursing Services. Focus Rounds on Infection Control/Hand Hygiene will continue to be completed weekly. Report will be reviewed at the monthly Quality Assurance Performance Improvement Committee meeting. **Monitoring Corrective Action:** Focus Round on Infection control/Hand Hygiene will be discussed at the Quality Assurance Performance Improvement meeting and monitored by the Infection Control Nurse and Director of Nursing Services for ongoing compliance to prevent recurrence.	

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4 136	Continued From page 2 them on the resident's overbed table without sanitizing or covering the overbed table with a clean barrier. Staff #53 had put on clean gloves and started removing the soiled dressing while Staff #52 assisted by placing the opened wound supplies onto the resident's bed, left in the wrapper. With the same gloves Staff #53 was observed to remove the dirty dressing, clean the wound, apply skin prep and the wound vac drape; then she proceeded to measure the wound depth with the same gloves. Discussed observations with both wound nurses and queried about practice of using same gloves between dirty dressing and clean dressing. Staff #52 stated that gloves are usually changed at least 5 times during a dressing change although that was not observed. Also, informed wound nurses that didn't observe them wash hands before putting on clean gloves. Both stated that they used hand sanitizing gel when they entered the resident's room. Informed them that observed them handling the wound vac machine and tubing with the clean gloves on before starting the wound care. Staff #52 stated that they will be sure to wash hands and change gloves between dirty and clean dressing change. During the dressing change R #31 was observed to jerk. Staff #37 stated that last pain med (MS Contin 60 mg) was given at 6 PM. The extended release pain meds are given 12 hrs apart. During the Interview with R #31, the resident stated that he experienced shooting pains during the dressing changes and currently rated pain at 8 on a zero to 10 pain scale. When asked R #31 said that he did not tell the MD about his pain due to not being able to tolerate the hydrocodone. Currently the Resident is being weaned off of the	4 136		

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4 136	Continued From page 3 Hydrocodone. The facility did not follow standards of practice for wound care for the resident's Stage 4 pressure ulcer that promotes healing and prevents infection.	4 136		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure that residents eating utensils and food preparation dishes were being properly sanitized. Findings include: On 10/16/2017 at 10:19 AM during the initial kitchen tour, the dishwashing machine temperature log for October documented temperatures for final rinse cycle were out of range and did not reach 180 degrees Fahrenheit for the final rinse cycle. According to Staff #54, when the staff take temperature and its wrong, it should be checked again. The procedure that the kitchen staff is to follow, is to attach a	4 159	**11-94.1-41(a) Storage and handling of food** **Corrective actions for residents affected:** Dishwashing machine repair completed on 10/19/17. **Measures and systemic changes to prevent recurrences;** The Food Service Manager re-educated dietary staff on the policy and procedure for hand washing dishes. Daily audit of temperature logs will be conducted to assure compliance with required water temperatures	10/27/17

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4 159	Continued From page 4 temperature strip to a coffee mug and run it through the dishwashing machine again. The temperature strip should have been attached to the log with low temperatures to show the correct temperature. During an interview, Staff #54 stated that the dishwasher was broken since June and the final rinse temperature was not reaching 180 degrees Fahrenheit. The facility had called the Hobart representative in July and was waiting to replace a part. On 10/17/2017 Staff #54 reported that the dishwasher repair was scheduled for 10/19/2017. The facility did not follow proper sanitation of the dishes, eating utensils and cookware to prevent the outbreak of foodborne illness.	4 159	**Monitoring Corrective Action for sustained corrections;** Temperature logs will be reported to QAPI Meeting by the Food Service Manager (or designee) and will be monitored by the Administrator to assure on-going compliance.	
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 interviews and electronic medical record (EMR) reviews, the facility failed to ensure that 1 of 16 residents (R #10) was consulted on personal preferences. Findings include: On 10/18/2017 at 2:19 PM R#10 was observed sleeping in bed. Staff #2 explained that staff	4 175	**11-94.1-43(c) Interdisciplinary care process AND 11-94.1.43 (d)** **Corrective Action for residents affected:** Resident #10 was immediately provided with soft call-light on 10/18/17 at 3:00 pm. **Identifying other residents having potential to be affected, and what corrective action will be taken:**	10/27/17

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4 175	Continued From page 5 were alert to resident's coughing as signal that assistance is needed and R#10 didn't want to use the soft call-light because often inadvertently triggered the call light by his/her head movements. Reviewed the resident's Care Plan (CP) which states "Potential for Decrease in ADL," that interventions dated 8/24/15 included: " I am to use a soft touch call light to call for assistance which is to be placed by my pillow near to my face. I will turn my head/face to touch the call bell. " Discussed with Staff #2, that intervention of soft call-light still on ADL CP and there was no intervention that staff should listen for the resident's coughing as signal for assistance. Staff #2 went to ask R#10 if he/she wanted a soft call-light and R#10 responded, " yes" by nodding his/her head. The resident's sister came to visit at that time and Staff #2 explained to her that R#10 now wanted to use the soft call-light. Staff#2 called for the soft call-light to be re-installed. The facility did not explore care alternatives through a thorough care planning process in which the resident could participate.	4 175	All residents will continue to be invited to care plan meetings with the Interdisciplinary Teams with family and resident participation to the extent practicable. Care plans for all residents were reviewed have been updated. **Measures and systemic changes to prevent recurrence:** The Director of Nursing Services re-educated nursing staff on the importance of reviewing/updating and following interventions as indicated in care plan and communication board in resident rooms. **Monitoring Corrective Action for sustained corrections:** On-going focus rounds for Adaptive Equipment will be completed weekly and reviewed at monthly QAPI meetings by Administrator and Director of Nursing Services to assure compliance.	
4 176	1-94.1-43(d) Interdisciplinary care process (d) Implementation of the overall plan of care shall be documented in each resident's medical record. This Statute is not met as evidenced by: Based on observations, staff interviews and	4 176		

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4 176	Continued From page 6 electronic medical record (EMR) reviews, the facility failed to ensure that 1 of 16 residents (R #10) was consulted on personal preferences. Findings include: On 10/18/2017 at 2:19 PM R#10 was observed sleeping in bed. Staff #2 explained that staff were alert to resident's coughing as signal that assistance is needed and R#10 didn't want to use the soft call-light because often inadvertently triggered the call light by his/her head movements. Reviewed the resident's Care Plan (CP) which states "Potential for Decrease in ADL," that interventions dated 8/24/15 included: " I am to use a soft touch call light to call for assistance which is to be placed by my pillow near to my face. I will turn my head/face to touch the call bell. " Discussed with Staff #2, that intervention of soft call-light still on ADL CP and there was no intervention that staff should listen for the resident's coughing as signal for assistance. Staff #2 went to ask R#10 if he/she wanted a soft call-light and R#10 responded, " yes" by nodding his/her head. The resident's sister came to visit at that time and Staff #2 explained to her that R#10 now wanted to use the soft call-light. Staff#2 called for the soft call-light to be re-installed. The facility did not explore care alternatives through a thorough care planning process in which the resident could participate.	4 176	Interdisciplinary Team will update care plans during care plan meeting and as needed. Communication boards will be reviewed and updated during care plan meetings.	