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
	125019	A. BUILDING: _____ B. WING _____	11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARE CENTER OF HONOLULU	1900 BACHELOT STREET HONOLULU, HI 96817

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4 000	Initial Comments A licensure survey was conducted from 11/6/17 through 11/9/17.	4 000		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observation, the facility failed to care for 2 (Residents #74 and #28) of 27 residents in the Stage 2 sample in a manner that promotes enhancement of his or her quality of life. Findings include: 1) On 11/6/17 at 1105 A.M. observed a staff member transporting Resident #74 from the shower room across the hallway to her room (#229). The resident was seated in a shower chair with a cloth draped over her body; however, the resident was exposed on left side, her bare skin could be seen from the hip to knee. 2) On Monday, November 6, 2017 observation of	4 115		

3/18 - copy to kwiton

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4 115	Continued From page 1 the dining was done in the dining room on the 1st Floor. Meals started being served at 11:30 AM. There were a total of 9 residents in the dining room. Resident #28 was sitting at a table by herself. There were three people delivering lunch trays from the food cart. At 11:55 AM Resident #28 was the only resident left to have her lunch tray delivered. At that time, she banged down on the table with clenched fists and stated in a loud voice "Hurry up". She had waited 25 minutes for her meal to be delivered to her. As there were 3 people delivering lunch trays and only 9 residents in the dining room, her meal was not delivered in a timely manner with disrespect towards the resident's dignity.	4 115		
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 observation, record review, interview with residents and staff members and review of	4 136		

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4 136	Continued From page 2 the facility's policy and procedures, the facility failed to address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status related to pressure ulcers (Resident #27); nutrtion (Residents #92, #14, #74 and #31), hydration (Resident #312) and medication (Residents #313 and #307). Findings include: 1) Resident #27 was admitted to the facility initially on August 10, 2004 for dependence on respirator (ventilator) status with diagnosis of amyotrophic lateral sclerosis. Other diagnoses included unspecified asthma, tracheotomy status, gastrostomy status, chronic pain, pulmonary embolism without acute coronary pulmonale, chronic respiratory failure, hypercapnia, acne, long term use of anticoagulants and personal history of other venous thrombosis and embolism. During a staff interview conducted on November 6, with staff #45, it was stated that Resident #27 has a Stage 4 pressure injury to the right sacral/ischial area. A medical record review was conducted on the same day and the Stage 4 pressure injury to the right sacral/ischial area was also documented. Weekly wound care documentation by physician wound consultant on November 25, 2014, identified a new pressure ulcer on the right buttock of Resident # 27. The consultant documented this pressure ulcer as unstageable. The pressure ulcer was facility acquired. This is the same pressure injury stage 4, identified during a staff interview and medical record review on November 6, 2017. A thorough medical record	4 136		

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4 136	Continued From page 3	4 136		

review conducted during the survey onsite and afterwards, did not show any documented clinical justification for delayed healing of this pressure injury.

The measurements of the pressure ulcer documented by consultant on November 25, 2014 was length 2 cm x width 1 cm with no depth documented. Below are measurements of the pressure injury that were documented on the weekly wound assessment over the three years. The measurements are in centimeters.

DATE	LENGTH	WIDTH	DEPTH
11/25/2014	2	1	0
3/4/2015	3	3	0
4/1/2015	1.5	0.5	0
7/8/2015	1.5	2.0	0.1
8/4/2015	4.3	2.2	0.2
9/2/2015	2.5	2	0.2
10/3/2015	6	3	1.5
11/3/2015	4	3	3
12/2/2015	2	2.5	3
1/13/2016	2	3	3
3/14/2016	1.5	1	2
4/13/2016	1	1	2.7
5/11/2016	1	0.8	3
6/15/2016	0.5	0.5	2.5
7/13/2016	0.5	0.5	2.7
8/10/2016	0.6	0.4	2.5
9/14/2016	1	0.8	2
10/12/2016	0.3	0.3	2.0
11/16/2016	0.4	0.5	2.5
12/14/2016	2.8	1.5	2.4
1/12/2017	2.5	2	2.8
2/2/2017	1.2	1	4
2/15/2017	1.2	1	3
2/22/2017	1.2	1.2	3
3/1/2017	1.2	1.2	3
3/8/2017	1.2	1.2	8

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3/15/2017	1.2	1.2	8
3/29/2017	2	1.5	4
4/3/2017	1.7	1.2	4
4/12/2017	2	2	5.5
4/26/2017	1.5	1.5	5.5
5/3/2017	1.5	1.5	5.5
5/26/2017	2.2	1.8	6.4
5/31/2017	2.2	1.2	3
6/8/2017	2	1.5	7
6/15/2017	1.5	1.5	7
6/26/2017	1.5	1.5	7
7/12/2017	1.5	1.5	7
7/19/2017	1.5	1.5	7
7/26/2017	1.5	1.5	7.5
8/17/2017	2	1.5	7.5
8/31/2017	2	1.5	7.5
9/13/2017	2.5	1.5	7.5
9/20/2017	2.5	1.5	7.5
10/3/2017	2.5	1.5	7.5
10/18/2017	1.5	1.5	7.5
10/25/2017	1.5	1.5	7.5
11/1/2017	1.5	1.5	6.8
11/8/2017	1.5	1.5	6.8

Documentation on the weekly wound assessments, showed that treatments changed over the three year period. From November in 2014 until November 2016, although the treatments changed, there were alternating treatments and the introduction of a wound vac. The outside measurements of the pressure ulcer decreased with the use of the wound vac, but the ulcer depth remained to fluctuate between 2-3 centimeters in 2016. Resident #27 started to attend the wound clinic in November 2016. At the wound clinic, debridement of the wound took place on several occasions during 2017 where the depth of the wound increased to 8 centimeters after necrotic tissue was removed. Below are a list of the treatments used until

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4 136	Continued From page 5 attending the wound clinic in November, 2016. "12/312014: Cleanse with normal saline. Pat dry and apply oreo thick Bacitracin ointment liberally. Cover with foam dressing and tape, daily and PRN. Apply protective ointment to buttock every shift and PRN. 3/4/2015: Cleanse right ischium with normal saline. Apply Bacitracin ointment and cover with boarded foam daily and PRN. 4/1/2015: Bacitracin to wound daily and cover with foam. 7/8/2015: Bacitracin to wound daily and cover with foam. 8/4/2015: Santyl with bactroban ointment after cleansing with normal saline and cover with foam dressing. 9/25/2015: Cleanse with normal saline, continue collagen and boarded foam dressing. Change daily. 10/3/2015: Cleanse with normal saline, apply Bacitracin then cover with non-boarded foam daily. New treatment: cleanse with normal saline, apply Santyl/Bactoban ointment and cover with non-boarded foam daily. 11/3/2015: Treatment wound vac initiated Friday 10/30/2015. May use wound vac dressing per physician consultant's recommendation, change every 72 hours per protocol. 12/2/2015: Wound vac, change every 72 hours. 1/13/2016: Wound vac, change every 72 hours. 2/17/2016: Wound vac, change three times a week. 3/14/2016: Wound vac, intermittently 10 minutes and 2 minutes off. 4/13/2016: Treatment change-4/11/2016-Cleanse right ischium pressure wound with normal saline, pat dry then place powdered collagen in wound bed and then cover with boarded foam daily and PRN when dislodged or	4 136		

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4 136	Continued From page 6 soiled. 5/11/2016: New Treatment- Cleanse with normal saline, pat dry, pack with iodofoam packing strips with hydrogel ointment and cover with foam dressing. 6/15/2016; Cleanse right ischium with normal saline, pat dry, pack with iodofoam packing strips with hydrogel ointment and cover with foam dressing. 7/13/2016: Cleanse right ischium pressure with normal saline, pat dry, pack with iodofoam packing strips with hydrogel ointment and cover with foam dressing. 8/10/2016: Cleanse right ischium pressure with normal saline, pat dry, pack with iodofoam packing strip with hydrogel ointment and cover with foam dressing. 9/14/2016: Cleanse with normal saline and pack with iodofoam strip with hydrogel and cover with foam dressing. 11/16/2016: Cleanse with normal saline and pack with iodofoam strips and cover with foam dressing. 12/14/2016: Apply silver alginate and cover with foam dressing. Resident #27 attended consultation visit with Infection Disease Physician (IDP) on November 1, 2016 for consult regarding non-healing right ischium wound. The IDP recommended to attend a Wound Clinic with further follow up with him. Resident #27 initially attended the Wound Clinic on November 30, 2016 for evaluation and treatment. Pre-debridement measurements of the pressure ulcer at the Wound Clinic were 0.5 cm length, 0.4 cm width and 2.2 cm depth. Post debridement pressure ulcer measurements were 2.4 cm length, 1.2 cm width and 4.7 cm depth with tunneling at 9-12 o'clock of 3 cm and undermining of 1.4 cm at 360. Level of	4 136		

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4 136	Continued From page 7 debridement was to bone. Description of procedure from the wound clinic stated the following: " After usual preparation, sharp debridement into necrotic bone and viable, as well as non-viable, surrounding tissue to the point of bleeding was performed utilizing a curette, scalpel and electrical cautery with excision of necrotic bone, muscle, subcutaneous tissue, dermis, skin and surrounding viable, as well as non-viable, tissue resulting in clear demarcation of wound margins. The wound was debrided to an acute state with some bleeding from the capillary bed. Intra-Operative Findings: Necrotic Bone. Material Removed: Necrotic bone and viable, as well as non-viable adjacent tissue to the point of bleeding." Treatment ordered was silver alginate inner dressing with outer foam dressing to be changed every 3 days and PRN. Advised the importance of strict off loading and repositioning and use of air mattress. Diagnosis of Pressure Ulcer of ischium, right, stage IV and Sacral osteomyelitis was given on November 30, 2016 at the Wound Clinic. On May 11, 2017 treatment by the Wound Clinic was changed to Grafix being applied to wound with Mepitel dressing in place and to continue offloading to right buttock. May 25, 2017, silver alginate dressings every 3 days and PRN was ordered with turns every 1 and a half hours. This treatment has continued. A review of laboratory reports for Resident #27 showed the following results from cultures collected from right ischium wound: 10/21/2016 - Methicillin Resistant Staphylococcus aureus (MRSA) 2/2/2017 - MRSA 2/24/2017 - Proteus mirabilis, Escherichia coli and MRSA 3/24/2017 - Escherichia coli, Klebsiella	4 136		

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4 136	Continued From page 8 pneumoniae, Proteus mirabilis and Enterococcus faecalis 5/22/2017 - Bacteroides fragilis and Pseudomonas aeruginosa 6/1/2017 - MRSA 8/8/2017 - Escherichia coli, MRSA and Bacteroides fragilis 8/31/2017 - MRSA and Escherichia Coli Results from a MRI of the Pelvis (Bone) performed on June 16, 2017 showed the following results: "1. New abnormal bone marrow signal and post contrast enhancement in the right issue tuberosity compared with 12/7/2016 suspicious for osteomyelitis. 2. Complex deep soft tissue decubitus ulcer tracking from the skin and subcutaneous tissues to the margin of the right ischial tuberosity with enhancing granulation tissue and without subcutaneous abscess collection at this time. 3. Persistent nonspecific presacral edema. 4. Diffuse marked muscle atrophy throughout the pelvis with nonspecific diffuse bilateral muscle edema and enhancement." Based on this information the facility failed to provide a documented clinical justification for the delayed healing of this pressure ulcer/injury. The facility failed to identify in a timely manner buildup of necrotic tissue in the wound which hindered healing of the wound. The facility failed to prevent a facility acquired pressure ulcer/injury from becoming infected with various bacteria requiring antibiotic treatment over the last 12 months. The facility failed to prevent infection in the pressure ulcer/injury from causing bone injury suspicious of osteomyelitis. 2) Resident #74 was admitted to the facility on 6/20/17 with diagnoses of pneumonia, severe	4 136		

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4 136	Continued From page 9 sepsis without septic shock, hypoxic respiratory insufficiency, chronic obstructive pulmonary disease, protein calorie malnutrition and dysphagia. The record review done during the Stage 1 phase found the resident's body mass index was 18.4 and there was no documentation in the medial record of the resident receiving a nutritional supplement. On 11/7/17 at 12:25 P.M. Resident #74 was observed eating in bed. The resident's tray was placed on the bedside tray. The tray consisted of minced chicken, peas and carrots, okai (rice gruel), dessert and hot tea. The resident reported she has okai as the rice gets too hard to swallow. On 11/8/17 at 8:26 A.M. found the resident having breakfast in her room. A concurrent observation was made with Staff Member #164. Inquired whether the resident receives boost. The staff member confirmed the resident had a container of ivory colored liquid on her tray. The staff member reviewed the resident's card and reported the resident's preference for boost is strawberry. Further queried the staff member whether the resident was provided with the strawberry flavored boost. Staff Member #164 stated it was the vanilla flavor and was agreeable to call the kitchen for strawberry flavored boost. The staff member brought the boost liquid and expressed the color was the same as the previous liquid. The two containers were compared and the boost on the tray was labeled with a "v" and the the new container was labeled with a "s". The staff member opened the container and smelled the liquid. Staff Member #164 confirmed it was strawberry. A record review done on the afternoon of 11/7/17 found Resident #74's history and physical dated 6/13/17. The diagnosis included protein	4 136		

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4 136	Continued From page 10 malnutrition with an unintentional weight loss of 10 lbs. over the last two months with labs documenting low albumin and total protein levels. At this time the resident was prescribed Boost Pudding. A review of the Nutrition Assessment dated 6/23/17 documents the resident was 56 inches in height and weighed 84 pounds. The resident's ideal body weight was 85 to 116 pounds. The dietitian recommended boost plus (preference for strawberry) with meals to support weight gain. Further review found a physician's telephone order dated 6/25/17 for Boost Plus, 120 ml three times a day with meals. A subsequent telephone order dated 7/25/17 was found for Boost VHC (very high calorie), 60 ml with med pass secondary to weight loss and underweight. These orders were handwritten into the Physician's Order sheet for July 2017, August 2017, September 2017 and October 2017. A review of the orders for November 2017 found no orders for the boost plus and boost VHC and there was no order for discontinuation of these supplements. A review of the facility's documentation of fluid intake consumed was found in a binder. The meal/fluid intake sheet notes codes for items consumed, "1" for milk, "2" for juice, "3" for pudding, "4" for cream, "5" for jello, "6" for coffee, "7" for soup, "8" for teapot, "9" for custard, "10" for small plastic cup and "11" large plastic cup. On the top right corner of the 11/7/17 intake sheet is a handwritten note: "B" boost, "N" Novo? (illegible) and "R" renal. A review of the intake sheet for 11/7/17 found the following: breakfast "6" 240, lunch "8" 240 and no documentation for dinner. Further review for 10/1/17 through 10/7/17 found no documentation that a	4 136		

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4 136	Continued From page 11 supplement was consumed. There is no documentation for breakfast on 10/1/17. There is no documentation for lunch on 10/1/17 and 10/5/17. Overall there is no documentation Resident #74 consumed the prescribed supplement of strawberry flavored boost with her meals. On 11/8/17 at 8:37 A.M. an interview and concurrent observation was done with Staff Member #6. A review of the Medication Administration Record (MAR) found the order for the Boost VHC supplement was not in the current record and there was no documentation the Boost VHC was being provided at med pass. The staff member confirmed the order was not in November 2017 MAR. On 11/8/17 at 8:56 A.M. an interview was conducted with Staff Member #87. Inquired whether the physician order for Resident #74's supplements were discontinued. A review of the resident's record found there was no order to discontinue both supplements (Boost with meals and Boost VHC with med pass). The staff member reported that the licensed nurses transcribes the orders to the MAR. At 9:04 A.M. Staff Member #87 provided documentation that the physician's orders were transcribed in the November physician's order and MAR. On 11/8/17 at 12:15 P.M. the Director of Nursing (DON) provided a copy of the intake record from the binder, the resident's meal card and reports of Resident #74's fluid intake from 10/1/17 through 11/7/17. The report documents the amount of fluid the resident consumed during this time period; however, does not document the consumption of nutritional supplement.	4 136		

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4 136	Continued From page 12 The facility failed to ensure Resident #74 was provided with a systematic approach to optimize her nutritional status. The facility failed to consistently document the consumption of the prescribed nutritional supplement to ensure the supplement was being offered and consumed by the resident. Based on this inconsistent system for documenting the resident's intake of the nutritional supplement there is a lack of evidence that the facility was monitoring the efficacy of its interventions. 3) Resident #14 was admitted to the facility on 2/28/17 with diagnoses which included Cerebrovascular hemorrhage, asthenia, Diabetes Mellitus II, and ESRD dependent on dialysis. Resident #14 had physician's orders (9/12/17) for Novasource Renal 120 ml by mouth once daily with lunch meals. The facility did not have a consistent, accurate system for monitoring and evaluating the use of nutritional supplements for Resident #14. A concurrent record review and staff interview regarding Resident #14's intake of Novasource Renal was conducted on the morning of 11/7/17 at 10:00 A.M. The Director of Nursing (DON) reported resident's supplement intake was recorded in a binder at the nurses station. The DON and Surveyor reviewed the intake binder for Resident #14 and found the documentation was inconsistent and sometimes blank. During the lunch meal, the Certified Nurses Aides (CNAs) were documenting Resident #14 had juice and tea and the supplement was not documented. The DON reported she knows the resident is receiving the supplement but noted the CNAs were likely documenting using the incorrect item code (ex. juice/tea). She then stated the CNAs also documented supplement intake in the "Point	4 136		

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4 136	Continued From page 13 of Care" system online. The DON was unable to access the "Point of Care" system and therefore asked a CNA to log on and show the Surveyor. The CNA logged in and pulled up the amount of fluids Resident #14 received over the past 30 days. A numerical value was noted in "Point of Care" without clearly defining what types of fluids and how much of each item Resident #14 received. The DON was then asked how she monitored her staff to ensure all residents received their nutritional supplements since she was unable to access the "Point of Care" system. The DON replied that she relied on the CNAs and the Registered Dietician for residents with nutritional concerns. She further noted she spoke with Medical Records to get her access to "Point of Care". The RD was present during the Surveyor's interview with the DON. The RD reported that she usually reviewed the intake binder to determine how much food and fluids a resident has received. The RD did not report using the "Point of Care" system to review supplemental intake. A review of Resident #14's care plan found one titled, "Resident at risk for fluid-nutritional imbalance related to End Stage Renal Disease, on Hemodialysis, Diabetes Mellitus, Congestive Heart Failure, diuretic use and dysphagia". The care plan for Resident #14 did not include the use of a nutritional supplement. A review of the Registered Dietician's (RD) notes for Resident #14 found the most current note dated 9/12/17 indicating the resident had a history of weight loss with variable oral intake placing him at risk for weight loss. The RD trialed Novasource Renal during Resident #14's lunch on 9/12/17 when the resident stated he liked the supplement. The RD recommended use of	4 136		

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4 136	Continued From page 14 Novasource Renal 120 ml every day with lunch meals to support his nutritional needs with ongoing Hemodialysis and to support weight maintenance. On the afternoon of 11/7/17 at 12:40 P.M., the DON provided Surveyor with Resident #14's fluid intake over the past month from "Point of Care". She stated to Surveyor, "You're confused. I'm confused. The staff was confused." She stated that she interviewed all persons (CNAs, kitchen staff, and nurses) and clarified that the kitchen staff never provided Resident #14 with juice during his lunch meals. The DON reported the documentation for juice in the intake binder was for Resident #14's supplement. However, the DON reported the intake binder was not considered a part of the medical record and instead would consider "Point of Care" as the medical record. The DON was again asked how she monitored nutritional supplement intake when she was unable to access the "Point of Care" system. The DON repeated that she relied on CNAs for accurate documentation and the RD to ensure the supplemental intake was meeting residents' needs. The facility failed to clearly document Resident #14's supplement intake. The lack of clarity made it unclear as to whether Resident #14 was receiving his nutritional supplement. The facility failed to have a system in place to ensure accurate documentation of nutritional supplements which placed residents at high risk for nutritional deficits. 4) Resident #31 was admitted to the facility on 2/9/16 with diagnoses which included acute diastolic congestive heart failure, sepsis, and end stage renal disease on Hemodialysis. Resident	4 136		

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4 136	Continued From page 15 #31 had physician's orders (2/9/16) for Novasource Renal 120 ml twice daily at morning snack and dinner meal as dietary supplement. The facility did not have a consistent, accurate system for monitoring and evaluating the use of nutritional supplements for Resident #31. A review of Resident #31's fluid intake found inconsistent record keeping. A concurrent record review and staff interview with the DON on the afternoon of 11/7/17 at 2:00 P.M. revealed the facility utilized an intake binder as well as "Point of Care" to document Resident #31's supplement intake. A review of the intake binder and the "Point of Care" program found inconsistent, missing and inaccurate documentation of Resident #31's supplemental intake. As with Resident #14, the DON was unable to access the "Point of Care" and she therefore had a CNA access the program for her. In "Point of Care" a numerical value was listed but did not specify how much of that was Resident #31's nutritional supplement. A review of the intake binder for Resident #31 found various entries varying from milk, juice, and "B". When asked what "B" stood for, the DON answered "Boost" (nutritional supplement). The Surveyor asked why Resident #31 was receiving Boost since there was no order for Boost but instead Novasource Renal. The DON reported the CNAs likely documented "B" but meant his "supplement". In addition to the inconsistencies, the intake binder did not have a section to document Resident #31's order for Novasource at morning snack. In "Point of Care", the numeric values were listed in 3 sections, which the DON explained was separated by shifts (day, evening, night). However, some of the day and evening shifts appeared to be documented at the same time. For example, on 11/5/17, the day shift documented Resident #31's intake at 1453	4 136		

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4 136	Continued From page 16 with 360 ml fluids; the evening shift documented her intake at 1454 with 360 ml; and the night shift documented her intake at 1802 with 240 ml. In "Point of Care" there wasn't a daily tally that totaled her intake for the day. As with Resident #14, the DON reported she relied on her CNAs to accurately document supplemental intake. She further relied on the RD to monitor Resident #14's supplemental intake. A review of Resident #31's care plan on the afternoon of 11/7/17 at 2:30 P.M. revealed a problem titled, "Resident at risk for fluid-nutritional imbalance related to End Stage Renal Disease on Hemodialysis, Diabetes Mellitus, and Congestive Heart Failure (CHF)". Interventions included, "Provide and serve supplement(s) as ordered: Novasource Renal 120 ml twice a day with morning snack and dinner meal". On the morning of 11/8/17 a review of the RD's notes for Resident #31 found one dated 10/3/17 which stated, "September labs for HD reviewed: mild low albumin despite good meal intake and drinking high protein supplement, potassium within normal limits, phosphorus within normal limits." The CNAs documented intake in two separate locations - intake binder and "Point of Care" program. The RD reviewed Resident #31's intake via the intake binder, which had differing values/information from the "Point of Care" system. The DON was unable to access the "Point of Care" program and instead relied on the CNAs to accurately enter data. The DON further relied on the RD to ensure Resident #31's nutritional supplements were meeting her daily nutritional needs. The facility failed to maintain an accurate system to monitor, assess, and	4 136		

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4 136	Continued From page 17 evaluate the efficacy for the use of nutritional supplements for Resident #31. 5) Resident #92 was admitted to the facility on 10/26/15 with diagnoses which included Asthenia, Dementia, Hypertension, and Atrial Flutter. Resident #92 had physician's orders: (1/18/16) Boost VHC 60 ml by mouth 3 times daily as medication pass; (5/20/16) Boost Plus/Carton (237 ml) 3 times daily with meals. The facility failed to accurately document, monitor, and evaluate the use of nutritional supplements for Resident #92. On the morning of 11/8/17 at 8:15 A.M. a review of Resident #92's Medication Administration Record (MAR) found blank spaces for the administration of "Boost VHC 60 ml orally 3 times daily as med pass". On the MAR for the month of November 2017, the assigned Licensed Nurses only signed off three times (11/4/17 day shift; 11/7/17 day shift; and 11/7/17 evening shift) to indicate the supplement was given. On the MAR for the month of October 2017, the assigned Licensed Nurses did not sign off for the entire month. The entire month of October 2017 was blank for Boost VHC 60 ml 3 times daily. An interview of Staff #6 on the morning of 11/8/17 at 8:30 A.M. revealed that the licensed nurses were not required to sign off for Boost VHC since the CNAs document all of it in the intake binder. When asked why Resident #92's November 2017 MAR contained three initials, Staff #6 stated the Licensed Nurses should be signing off for Boost VHC on the MAR. A review of the RD's noted for Resident #92 found the latest quarterly assessment dated 11/7/17 which indicated, "Resident continues with poor meal intake, however, drinks Boost Plus	4 136		

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4 136	Continued From page 18 very well." The previous assessments were: an annual dated 8/15/17; a quarterly dated 5/23/17; and another quarterly dated 3/7/17, all of which noted, "Resident continues with poor meal intake, however drinks Boost Plus very well at meals." On the morning of 11/8/17 at 11:00 A.M. a review of Resident #92's care plan found one titled, "Risk for fluid-nutritional imbalance related to poor intake, dysphagia, and Congestive Heart Failure. 1/19/16 weight loss/underweight. 4/19/16 weight loss." Care plan interventions included, "Provide and serve supplement(s) as ordered: Boost Plus 120 ml three times daily with meals, Boost VHC 60 ml three times a day as med pass." The facility failed to accurately document, monitor and evaluate the use of nutritional supplements for Resident #92 despite being identified as nutritionally at risk. Facility policies were reviewed on the morning of 11/8/17 at 10:30 A.M. and found one titled, "Therapeutic Diets" with revision date of November 2015. The policy noted, "7. The Clinical Dietitian and nursing staff will document significant information relating to the resident's response to his/her therapeutic diet in the resident's medical record." Another policy titled, "Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol" with revision date of September 2012 noted under "Monitoring: 1. The Physician and staff will closely monitor residents who have been identified as having impaired nutrition or risk factors for developing impaired nutrition. Such monitoring may include: a. (1) Evaluating the resident's response to interventions should be based on defined criteria for improvement/worsening of nutritional status; for example, stabilization of weight, laboratory	4 136		

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4 136	Continued From page 19 values, or food/fluid intake." 6) On 11/06/2017 at 11:06 AM while observing Resident (Res) #312 in her bed it was noted that resident had dry lips and when asked if she was thirsty Res #312 complained of "dry mouth". While looking around resident's room for fluids, that might have been left for her, it was noted that there were 3 new empty cups on resident's bedside table. Review of resident's care plan (CP) found that resident is "Risk for fluid-nutritional imbalance/deficit r/t variable intake, chew/swallow deficit, CHF, diuretic use, CKD, UTI, and wt below IBW." Goal for this problem was "Resident will not have s/sx aspiration, dehydration or fluid overload." Some interventions listed to meet this goal were "Encourage, cue, assist or feed as needed to complete at least 50% of meals and at least 300 cc fluids with meals and 120 cc fluids between meals. Monitor for s/sx of dehydration. ex: poor skin tugor, decreased or dark urine output, wt loss, dry mucous membranes, reduced BP, etc. Provide and serve diet as ordered: Regular moist minced solids, nectar thick liquids." Review of resident's documented fluids from 10/21/2017 - 11/05/2017 showed that resident did not have a daily intake of 1,260 cc of fluids as recommended on the resident's CP. Res #312 had the following documented fluid intake: 620 cc on 10/21/2017 640 cc on 10/22/2017 240 cc on 10/23/2017 240 cc on 10/24/2017 240 cc on 10/25/2017 870 cc on 10/26/2017 720 cc on 10/27/2017 600 cc on 10/28/2017	4 136		

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4 136	Continued From page 20 360 cc on 10/29/2017 720 cc on 10/30/2017 840 cc on 10/31/2017 600 cc on 11/01/2017 720 cc on 11/02/2017 240 cc on 11/03/2017 540 cc on 11/04/2017 480 cc on 11/05/2017 On 11/08/2017 at 2:55 PM interviewed staff #156 who explained that fluids are given to residents during: meals, with snacks, per resident request, during rounds (nurses and CNAs will assess if residents need anything and at that time will offer fluids), and during medication administration the nurses offer fluids unless the resident is on fluid restrictions. Staff #156 and #266 both agreed that Res #312 was not on fluid restrictions. These staff did state that resident has order for thickened liquids (nectar thickened liquids) and this type of liquid cannot be left with resident for her own safety to prevent her from choking. Staff #156 was able to state what CNAs should be looking for and reporting to the nurse if the resident is dehydrated, such as dry mouth, dry lips, and dry mucous. On 11/08/2017 at 3:06 PM interviewed staff #15 who was able to state signs and symptoms of dehydration "resident would say they are thirsty" and "look for dry skin, skin is pale, texture is dry, dry lips". The facility failed to offer sufficient fluids to maintain hydration for 1 (Resident #312) of 2 residents in the Stage 2 sample who are at risk of dehydration due to variable intake, swallow deficit, CHF, diuretic use, CKD, and UTI. 7) Resident #313 was admitted to the facility on	4 136		

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4 136	Continued From page 21 11/4/17 with the following admission diagnoses: acute delirium due to constipation; abdominal pain due to constipation; Alzheimer's dementia; constipation; caregiver burn out; DNA status; hyperlipidemia; chronic A-fib; DVT; and insomnia. A record review was done on 11/6/17 at 11:00 A.M. found physician's orders for celexa 10 mg. one tab by mouth once daily for a diagnosis of Alzheimer's dementia with late affect; seroquel 25 mg., 0.5 tab (12.5 mg.) by mouth twice daily, no diagnosis; seroquel 25 mg. one tab by mouth at bedtime, no diagnosis; warfarin 4 mg. one tab by mouth once daily for DVT; and melatonin 5 mg. tabs, 2 tabs (10 mg.) by mouth at bedtime for diagnosis of insomnia. Further review found no documentation of a care plan for the use of seroquel, warfarin, and celexa including side effects and non-pharmacological interventions. Also noted there is no documentation of diagnosis related to the use of seroquel. The behavior monitoring for the use of the celexa and seroquel included monitoring the resident for change of mood. Further review found an admission summary from the acute hospital with principle diagnosis of acute delirium due to constipation and Alzheimer's dementia. A review of the resident's admission history and physical notes the resident was seen at the emergency department for confusion and abdominal pain but was discharged home. Further review noted at home the resident complained of abdominal pain and also presented with confusion, agitation, hallucinations and delusions and almost hit his daughter. The Admission Orders dated 11/3/17 documents medication of celexa 10 mg. one tab daily, seroquel 25 mg (1/2 tab) twice a day, seroquel 25 mg. at bedtime for Alzheimer's	4 136		

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4 136	Continued From page 22 dementia	4 136		
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on observations, record review and interview with staff members, the facility failed to ensure sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, psychosocial well-being of each resident. Findings include: 1) Cross Reference to §11-94.1-30. The facility failed to provide treatment for Resident #37's facility acquired Stage 4 pressure ulcer to ensure healing of the wound, prevent infections and a clinical justification of the delay in healing of the ulcer. 2) Cross Reference to §11-94.1-30. The facility failed to ensure the nursing staff accurately documented, monitored and evaluate the use of nutritional supplements for residents who were identified as nutritionally at risk (Residents #14, #31, #92 and #74).	4 148		

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4 148	Continued From page 23 3) Cross Reference to §11-94.1-30. The nursing staff failed to ensure Resident #312 received adequate hydration. The resident's fluid goal was 1260 cc of fluids per day. A review of the intake records from 10/21/17 through 11/5/17 documents the resident did not meet this goal, the range was from 240 cc to 870 cc a day. The resident also reported to have been thirsty and observed to have dry lips. 3) Cross Reference to §11-94.1-30. The facility failed to ensure the nursing services were provided for Resident #313 for the use of antipsychotic, antidepressant and anticoagulant medications. The staff did not acquire a physician's order to confirm the indications of use of an antipsychotic and antidepressant. The nursing staff also failed to assess the resident's behaviors associated with the use of these medications to ensure monitoring of the efficacy of the medications. Also, the nursing staff did not develop a care plan for the use of the antidepressant, antipsychotic and anticoagulant. The nursing staff also failed to provide adequate monitoring for the use of heparin was done for Resident #307. Also, a care plan was not developed for the use of heparin. 4) Cross Reference to §11-94.1-30. The nursing staff failed to ensure refrigerated medications were stored at the proper temperatures as evidenced by missing documentation of the refrigerator temperature log. The nursing staff also failed to ensure attestation was done for dispensing and reconciling of narcotics. The nursing staff also failed to dispose of two expired vials of vaccines. 5) Cross Reference to §11-94.1-43(b). The	4 148		

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4 148	Continued From page 24 nursing staff failed to ensure a care plan was developed to treat/heal a pressure ulcer for Resident #284 who was admitted with a pressure ulcer. The nursing staff also failed to develop a care plan for Resident #307 for the usage of heparin.	4 148		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation and interview the facility failed to ensure food was stored under sanitary conditions. Findings include: During the initial tour on November 6, 2017, it was observed in one of the refrigerators there were several items that had no labeling on them to indicate expiry dates or dates when they were prepared. These items were Papaya, cut and individually wrapped, cups of apple juice and other juice drinks and fruit cups. In another refrigerator there were 8 juice containers that had no labeling on them to indicate date prepared and	4 159		

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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
4 159	Continued From page 25 no expiry dates. Staff #18 was present when the initial tour was conducted and validated these items were not labeled. Lack of labeling of these items has the potential for the items to be used beyond their expiry date posing the risk of food borne pathogens being passed on to residents.	4 159		
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on record review and staff interview the facility failed to develop a comprehensive care plan with measurable objectives and timeframe to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 (Residents # 284 and # 307) of 18 care plans of 28 residents in the Stage 2 Sample. Findings include: 1) On 11/07/2017 at 12:44 PM reviewed Resident (Res) #284's Comprehensive Care Plan (CP) for completeness. Res #284's initial admission to the facility was on 08/30/2017 with an unstageable pressure ulcer (PU) on his sacral area. Review of resident's electronic medial record (EMR) found that there was no CP for his unstageable PU. Review of resident's Minimum Data Set (MDS) 3.0, 5 day scheduled assessment, dated	4 174		

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	125019	A. BUILDING: _____ B. WING _____	11/09/2017

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4 174	Continued From page 26 09/06/2017 documented that resident had an unstageable PU that was 8 cm long X 7 cm wide X 0 cm deep with eschar covering the wound bed. Further review of resident's EMR found that resident was sent out to an acute facility on 09/07/2017 and resident was re-admitted to the facility on 09/12/17 from the acute facility. After resident's return there was an MDS 3.0 Admission Assessment, that was completed on 09/19/2017, that had documented resident had an unstageable PU which measured 8 cm long X 7.2 cm wide by 0.1 cm deep with slough covering the wound bed. On 11/07/2017 at 2:34 PM interviewed staff #145 to verify that she was familiar with resident #284 and she confirmed that she was familiar with his care. Showed staff #145 Res #284's CP and inquired where was the resident's CP to address the unstageable PU. Staff #145 stated she would investigate and find the CP. On 11/08/2017 at 7:49 AM spoke with staff #220 who stated that she had to call the technical support department to get Res #284's CP. Staff #220 stated that her MDS coordinator had made a mistake and changed dates for Res #284 CP to start on 9/21/17 which was actually started when he was initially admitted to the facility on 08/30/2017. Staff #220 was asked and provided the facility's policy on PU assessment and documentation. It is noted that in the facility's policy, Pressure Ulcer/ Injury Risk Assessment, which was revised on July 2017, states the following "5. Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments, the conditions of the skin, the resident's overall clinical condition, and the resident's stated wishes and goals. a. The interventions must be based on current,	4 174		

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4 174	Continued From page 27 recognized standards of care. b. The effects of the interventions must be evaluated. c. The care plan must be modified as the resident's condition changes, or if current interventions are deemed inadequate." On 11/09/2017 at 12:51 PM staff #145 gave a copy of Res #284 CP. Staff confirmed that this CP for the unstageable PU was from the resident's second admission (09/12/2017) and initiated on 09/20/2017. Staff #145 confirmed that resident's CP did not have anything in place for the care of the unstageable PU prior to 09/20/2017. On 11/09/2017 in the afternoon inquired with staff #220 if there was a CP for Res #284 for his initial admission for resident's PU and there was none provided. 2) On 11/08/2017 at 4:57 PM review of Res #307 EMR showed that this resident was ordered and receiving "Heparin 10,000 unit/mL inject 0.5 mL (5,000 units) SQ every 12 hours until patient ambulates for Dx: DVT Prophylaxis" since the resident's admission on 10/23/2017. Further review of Res #307 EMR and her CP found that there was no care plan for the use of Heparin. On 11/09/2017 at 10:34 AM interviewed staff #17 who was taking care of Res #307 and this staff was able to state that she would monitor resident for signs and symptoms of side effects from Heparin such as bruising and bleeding and stated that this information is documented in the nurse's progress note. Interviewed staff #201 right after and he confirmed that there was no CP for Heparin use for DVT prophylaxis for Res #307. Further review of resident's hard copy chart found that there were no labs done with this resident	4 174		

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4 174	Continued From page 28 since admission to the facility and no orders for labs to be done to monitor resident's platelets. On 11/09/2017 at 11:39 AM continued review of Res #307's medical record found a nutritional assessment completed by RD #1 on 10/27/2017 at 13:27. RD #1 listed pertinent medications: "Abx., Tylenol, Phoslo, Namzaric, Na bicarb, Tamsulosin, Lantus, Calcitriol". RD #1 did not document that the resident was getting Heparin injections twice a day. Heparin is an anticoagulant and is considered a high risk medication and there was no diet restriction related to this in this nutritional assessment. On 11/09/2017 at 11:50 AM spoke with staff #263 and when inquired about labs for Res #307 such as a Partial Thrombolastin Time (PTT) he ordered a Complete Blood Count (CBC) with differential and Complete Metabolic Profile (CMP) to be done the next day. On 11/09/2017 at 12:16 PM met and interviewed RD #2, to discuss Res #307's Nutritional Assessment that was completed by RD #1. When asked if this resident had any food restrictions RD #2 stated that the facility's menu is "to provide a menu consistent to supply an amount of vitamin K in our menu to support/ balance with medical anticoagulation." Res #307 did not have any food restrictions in place even though she was receiving Heparin injections twice a day to prevent DVTs. On 11/09/2017 at 1:49 PM spoke with the facility's contract pharmacist, regarding lab monitoring for heparin that Res #307 is receiving subcutaneous. Pharmacist stated that this resident does not require PTT lab monitoring for bleeding time, only requires close watch of CBC and H and H.	4 174		

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4 174	Continued From page 29 The facility failed to develop a comprehensive care plan with measurable objectives and timeframe to meet a resident's medical needs for an identified unstageable PU and use of a high risk medication (Heparin) needed to prevent Deep Vein Thrombosis for 2 of the 28 residents from the Stage 2 sample which may have resulted in injury to these residents.	4 174		
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 a random observation and interview with staff member, the facility failed to ensure hand hygiene practices to reduce the spread of infections and prevent cross-contamination was implemented. Findings include: On 11/8/17 at 11:07 A.M. observed Resident #66's wife approach the medication cart which was parked in front of the nurses' station, the wife grabbed one of four cartons of thickened water, unscrewed the cap and poured the thickened water in a plastic cup. The cap was replaced on the carton and the wife put the carton back with the other cartons. At this time the Director of Nursing (DON) was approaching the cart and was	4 203		

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4 203	Continued From page 30 asked whether the resident's wife is allowed to get water from the medication cart. The DON responded the wife has been trained by the speech therapist; however, the wife needs to inform the nurse. Further queried whether the resident's wife was also instructed on hand washing before pouring the thickened water from the carton. The DON instructed another licensed nurse to talk to Resident #66's wife. On 11/8/17 at 11:18 A.M. an interview was conducted with Resident #66's wife. The resident's wife reported when she arrived she knew her husband was thirsty and she will usually ask "one of the ladies" but nobody was around so she went to get the water herself. Inquired whether she has been provided any instructions regarding getting water for her husband from the nurses' cart. She responded she is not supposed to get water from the cart but could not get assistance and her husband was asking for water. On 11/8/17 at 1:55 P.M. the Staff Member #6 confirmed the cartons of thickened liquid on the nurses' med carts are used for residents that required thickened or nectar consistency liquids during medication pass. The facility failed to ensure hand hygiene practices are performed by visitors or refrain visitors from touching items on the medication cart which is utilized by staff members to dispense medications to residents of the facility.	4 203		

4 115 Completion Date: 12/24/17

Resident #28 has been discharged to home and #74's dignity is being observed.

All resident has the potential to be affected by the deficient practice.

Director of Nursing (DON) educated all staff on the CCOH shower procedure and dining room procedure. An audit checklist was created which includes 3 resident interviews daily by the Unit Managers (UM) and Shift Supervisor X2 weeks, weekly X4 weeks and then monthly.

The Administrator or designee will monitor weekly through results of interviews. Results will be presented to QAPI committee monthly to maintain compliance.

4136 Completion Date: 12/24/17

Residents #92, 14, 31 and 74 Notional Supplement documentations were corrected. Resident #312 has been discharged to a care home facility. Resident #307 has been discharged to home. Resident #313 has been discharged from the facility.

All residents who are newly admitted to CCOH has a potential to be affected by the deficient practice. DON has reviewed 100% of Residents to identify additional residents who may have been affected by the deficient practice. No other resident was identified as having been affected.

DON or designee will monitor weekly through review checklist. Result of the review will be reported to QAPI monthly to maintain compliance. DON is responsible for implementation and SDC or UM are responsible for on-going compliance.

4 148 Completion Date: 12/24/17

Staffing levels were evaluated relative to deficiencies found in F-314, F-325, F-327, F-329, F-431 and F-279.

All residents have the potential to be affected. DON and Administrator reviewed staffing levels due to deficient practice. As all deficient practices have been resolved no other residents are continuing to be affected.

Administrator/ DON or designee will review staffing schedules and the scheduler will report any variables to DON and Ums.

DON or designee will monitor weekly by reviewing staffing levels to maintain care of residents. The DON is responsible in implementation and UMs are responsible for ongoing compliance. Any finding will be reported to QAPI committee monthly.

4159 Completion Date: 12/24/17

Unlabeled items in the refrigerator were destroyed of.

All residents have the potential to be affected. Administrator and Dietary supervisor audited refrigerators and no other items were located with missing dates.

Dietician in-serviced dietary staff on labeling and dating items stored in the refrigerator. An audit tool was created for Dietary Supervisor and Dietician to check for missing dates.

Administrator or designee will monitor weekly by reviewing audit tool to maintain 100% compliance. The Administrator is responsible in implementation and Dietary Supervisor is responsible for ongoing compliance. Any finding will be reported to QAPI committee monthly.

4174 Completion Date: 12/24/17

Resident #284 Care Plan has been corrected. Resident #307 has been discharged to home.

All residents who are newly admitted to CCOH has a potential to be affected by the deficient practice. DON has reviewed 100% of Residents to identify additional residents who may have been affected by the deficient practice. No other resident was identified as having been affected.

DON or designee educated all Licensed Nurses (LN) on the Admission Process to ensure Care Plans are completed within the first 24 hours of admission. A checklist was developed for UM to complete for all admission daily and report to DON daily.

DON or designee will monitor weekly by reviewing completed checklist weekly to maintain 100% compliance. The DON is responsible in implementation and UMs are responsible for ongoing compliance. Any finding will be reported to QAPI committee monthly.

4 203 Completion Date: 12/24/17

Resident #66's wife was given education. Thickened liquid container was destroyed by the Unit Manager.

Residents in U4 has potential to be affected by the deficient practice. All other units were observed and did identify deficient practice.

DON completed 100% education for LN and CNA to ensure that any resident visitors will be given a gentle reminder as needed to ask the staff for any needed items and refrain from touching supplies or items that are used for other residents in the unit. Daily Unit Rounds tool develop for UM to be completed to maintain compliance.

DON or designee will monitor weekly by reviewing completed tool to maintain 100% compliance. The DON is responsible in implementation and UMs are responsible for ongoing compliance. Any finding will be reported to QAPI committee monthly.