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	125061	A. BUILDING: _____ B. WING _____	06/29/2018

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4 000	Initial Comments A relicensing survey was conducted on June 26, 2018 through June 29, 2018 by the Office of Health Care Assurance (OHCA). Census was 48 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 record review and interview, the facility failed to ensure the resident environment remained free of accident hazards by serving food that was contaminated with toxic chemicals. Less than ten residents ingested brownies that were baked in an oven that contained a chemical cleaning agent. The deficient practice placed vulnerable residents at an increased risk for serious illness and/or injury. Findings include: Review of the incident report #6397 indicated on Saturday, 6/23/18 during a cooking activity with	4 136	The submission of this plan of correction does not constitute an admission with the allegations of non-compliance. It is submitted solely as the facility□s credible allegation of compliance as mandated by Federal and State regulations. 4136 11-94.1-30 Resident Care: Corrective Action #1: Specific/ Other Residents:	7/31/18

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4 136	Continued From page 1 the residents, staff (S) 31 baked brownies in the kitchen oven and was unaware that oven cleaner had been applied to the oven and had not been cleaned/ removed prior to baking the brownies. Once the kitchen staff returned to the kitchen and became aware that the brownies were placed in the oven for baking, the brownies were removed, covered and set aside by the kitchen staff. The following morning on 6/24/18 different kitchen staff saw the covered brownies sitting on the counter and provided them to the residents as the morning snack. The brownies were passed out to several residents, one family member and one staff member who ingested them. As soon as it was discovered that the brownies had been ingested the Administrator, director of nursing services (DNS) and dietary manager were notified. The poison control center was contacted. The medical director, family members, power of attorneys and guardians were all notified of the incident. The incident was reported to the office of healthcare assurance (OHCA) on 6/25/18 at 9:25 AM. Per recommendations of the poison control center all residents were placed on alert charting for 72 hours for signs and symptoms of physical distress: nausea, vomiting, abdominal pain, burning in the throat and diarrhea. S31, S11 and S35 were placed on suspension pending further investigation. The Administrator was interviewed on 06/26/18 at 11:00 AM and confirmed the documentation was an accurate account of the incident and the investigation was complete. During the survey investigation of the incident, several of the residents, one family member and staff were interviewed by the survey team. It was determined that less than 10 residents ingested	4 136	The 10 residents were identified as having ingested potentially contaminated food; no adverse reactions or signs and symptoms of illness were reported. MD and families were notified and the residents were monitored. The employee involved was suspended and received 1:1 counseling on non-dietary staff not utilizing kitchen equipment prior to returning to work. Systemic Changes A Sign was added to kitchen doors stating Only Authorized/Certified Dietary Staff are allowed in the Kitchen. Ring Door Bell for Assistance. Kitchen Staff education on the use of the Equipment Being Cleaned signs to prevent ovens from being used when cleaning is in process. Created a Safe Zone for other staff to come into the kitchen to access the Resident Beverage Service Area. Staff are not to pass those Safe Zone lines. Staff educated on the Safe Zone. The main hallway and back kitchen door will be locked to ensure access to the kitchen is through the Safe Zone entrance for assistance or the door bell is used for assistance. Kitchen Staff educated to discard food that may be contaminated. Staff educated to communicate dietary needs/changes/activities to the head cook. Monitoring: Kitchen observations will be completed by the Administrator [or designee] weekly for the next 3 months to validate no unauthorized staff in the kitchen and the use of the Equipment Being Used signs. Issues identified will be immediately addressed. Results of the observations	

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4 136	Continued From page 2 the brownies that were exposed to the oven cleaner. No adverse actions or signs and symptoms of illness were reported by the residents/ guests who consumed the brownies nor were any residents treated in an acute health care facility for illness. Based on record review and interview the facility failed to ensure the resident's environment remains free from accident hazards for two Residents (R) R46 who wandered out of the facility unsupervised on two occasions and R11 who wandered out of the facility unsupervised on one occasion . The deficient practice placed the vulnerable residents at a high risk for injury. Findings include: Review of the first incident (report #4512) dated 08/06/17 stated that R46 had been found walking around another long term care facility located 0.2 miles away. The other facility called to report that R46 was wandering in their facility. Nursing staff had last seen the resident 10 minutes prior to the telephone report. R46 was brought back to the facility and the assessment revealed that she did not suffer any harm. The elopement evaluation was completed and the care plan was updated by the nursing staff to include the following interventions: Identity patterns of wandering; provide a quiet area for the resident; keep R46 supervised at all times and maintain as much consistency as possible in timing of activities of daily living (ADLs), caregivers and daily routine; monitor R46 behavior episodes to identify triggers, monitor triggers for wandering, walk alongside resident when she starts to wander or get agitated; provide structured activities, toileting, ambulation inside and outside and snacks.	4 136	will be reported to QAPI monthly. Responsible Person: The Administrator and Dietary Manager will be responsible for ongoing compliance. Date of Correction: Compliance will be met by 7/31/18 and on an ongoing basis. Corrective Action #2: Specific Residents: Resident #11 and #46 elopement assessment and plan of care reviewed and updated as indicated. Laulima side-entrance rolling gate and swinging latch gate accesses immediately secured with key-only access and emergency access procedure posted. Other residents: Other residents identified at risk for elopement, the care plan reviewed and updated as indicated. Systemic Changes: The DNS and Maintenance Supervisor will in-service staff regarding facility safety practices as it relates to residents leaving the facility unsupervised. Staff educated on elopement risk factors and prevention measures including rounding to verify exterior doors/gates are secured and timely response to door alarm. Non-essential facility gates have been secured with key-only access and emergency access procedures posted	

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4 136	Continued From page 3 Review of the second incident (report #6290) revealed that on 05/08/18 R46 was found outside in the parking lot unsupervised. R46 was escorted back into the building without incident. R46 was confused and unable to state why she went outside by herself. The resident was assessed for pain and/ or injury, none noted. The resident has an elopement care plan with multiple interventions in place and has a history of wandering. An interview was conducted on 6/27/18 at approximately 10:00 AM with staff (S)1 and revealed that S1 observed R46 walking in the parking lot on 05/08/18 and appeared agitated and confused, she asked her where she was going and she stated that she didn't know. S31 escorted R46 back into the facility and reported to the charge nurse. Record review of the nursing notes dated 05/08/18 stated Resident was found outside in the parking lot and was brought back into the building. On 06/27/18 at approximately 10:30 AM R46 was observed to walk with a steady gait with a family member (F)1. During an interview with F1, he stated that although she is 94 years old, R46 is very active and walks very well. F1 confirmed he was aware of both incidents where she had wandered out of the facility and that she is at risk for wandering. Interdisciplinary team meeting notes stated new interventions were added to the care plan on 06/14/18 that included education to staff about keeping the outside gates locked.	4 136	allowing for single entry access and exit to Laulima building and a single entry access and exit to Lokahi building. Monitoring: Daily Rounds at different times of the day will be completed to ensure safety and verify door alarms working and gates are secured for the next 3 months. Issues identified will be immediately corrected. The Administrator will audit exterior doors/gates checks and timely response to door alarms weekly for the next 3 months to ensure compliance. Results will be reported to QAPI monthly and on an ongoing basis. Responsible Person: The Administrator will be responsible for ongoing compliance. Date of Correction: Compliance will be met by 7/31/18 and on and ongoing basis. Corrective Action Plan #3: Specific Residents: Resident #17 - assessment completed, risk and benefits reviewed, and an informed consent signed. Other Residents: Other residents with enabler bars were reviewed and assessed for appropriateness, risk and benefits be reviewed with the resident or resident representative and obtained informed consent as indicated.	

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4 136	Continued From page 4 Reviewed care plan dated 06/14/18, noting the following interventions: Provide appropriate supervision for me and ensure I am closely monitored..... ensure exit door alarms are on .....please ensure I am being supervised and monitored at all times, as I tend to wander off into crowds or look for an exit. Reviewed elopement policy #SNCP stated the elopement evaluation will be completed upon admission, readmission, an actual elopement.... Findings Include: During an interview on 06/27/18 at 2:46 PM with the director of nursing services (DNS) who confirmed R11 had eloped from the facility on 06/14/18 at 8:00 PM and was found sitting in the facility van out in the parking lot. DNS stated R11 was immediately escorted back into the facility and found without injuries at the time. DNS stated R11 was subsequently placed on elopement risk watch (safety checks every 15 minutes) by facility staff. Interview on 06/28/18 at 1:18 PM with staff (S) 50 regarding R11's elopement from the facility on the evening of 06/14/18. S50 stated she was the licensed staff working with two or three certified nurse's aides (CNA's) but does not recall exactly how many CNA's there were that evening. S50 stated R11 was restless that evening and was usually ruminating about smoking or his dog. R11 wanted to sit in the breezeway and was therefore placed there. S50 stated she was monitoring R11 through the windows the whole time when another resident requested to use the bathroom. S50 said she assisted this other resident back to her room (room 4) and toileted her. S50 said when she came back out with this other resident	4 136	Systemic Changes: The DNS or Designee will in-service licensed nurses on the enabler bar policy and procedures, completing assessment, reviewing risk and benefits of use and obtaining consent for use from resident and/ or family. Facility obtained revised Appendix PP. Monitoring: DNS or Designee will audit enabler bars for assessment, risk and benefits and consents weekly for the next 3 months to ensure compliance. Any identified issues will be corrected. Results will be reported to QAPI monthly for 3 months. Responsible Person: The DNS will be responsible for ongoing compliance. Date of Correction: Compliance will be met by 7/31/18 and on an ongoing basis.	

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and placed her back into the recliner, S50 said she noticed R11 was gone. S50 stated she was the only staff at the nurse's station and day area at the time of the incident due to the CNA's were assisting other residents in their rooms at the time. S50 stated she immediately searched for R11 and found the Velcro stop sign on the side door detached. R11 was found in the facility van pretending to be driving. S50 stated she escorted R11 back into the facility and subsequent assessment found no injuries. S50 stated the incident occurred at approximately 7:45 PM.

On 06/28/18 at approximately 2:20 PM, two surveyors proceeded to retrace R11's elopement path on the evening of 06/14/18. The surveyors started at the breezeway, entered a door into the unit then headed toward the side door next to room 15 that led to the outside parking lot. After removing the Velcro stop sign, the surveyors opened the door and the door alarm started chirping. Once outside, the surveyors noted no facility staff came to check who or what triggered the door alarm. The surveyors took notice of two gates, one swung open like a door and the other was a rolling gate. The door- like gate was closed by a latch in addition to having a chain latch. The rolling gate which was near a busy road had no closing latch and the additional chain latch was not applied. The surveyors were able to easily roll the gate open which led to the busy road behind it.

On 06/28/18 at approximately 2:45 PM, the surveyors brought to the attention of facility administrator and maintenance director the unsecured rolling gate outside the facility side door. The maintenance director stated he was the person responsible for checking the latching of the gates and must have missed it. Discussed the

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seriousness of residents eloping from the facility and the potential for harm/injuries. Options were discussed to increase safety for residents in the facility.

On 06/27/18 at 12:45 PM, record review of progress notes dated 06/14/18 at 9:26 PM reflects documentation by S50 regarding R11's elopement and subsequently found in facility van out in the parking lot.

On 06/27/18 at 2:46 PM interview with DNS who provided the "Event Report" dated 06/18/18 concurred with documentation regarding R11's elopement incident on 06/14/18 at 8:00 PM.

Based on observation, resident and staff interview and record review (RR) the facility failed to assess Resident (R) 17 for risk of entrapment from bed rails prior to installation, failed to review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation of bed rails.

Findings Include:

On 06/26/18 at 01:16 PM while interviewing R17 noted that he had grab bars on his bed. Asked R17 about the grab bars and he stated that he was glad that they were on his bed, stated it makes it easier for him to move around in his bed especially when staff are assisting him with activities of daily living (ADL's) and cleaning him up. R17 stated that he rolled off his bed once this year when he did not have the grab bars on his bed.

On 06/28/18 at 01:33 PM RR found that res fell on 3/27/18. Per progress note, dated 3/27/18 and timed at 0305, in R17's electronic medical record

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4 136	Continued From page 7 (EMR), R17 was found sitting on the floor next to his bed with his blanket, denied hitting his head and no pain . Three staff assisted resident up off the floor. RR did not find the risk assessment or consent to use the bed rails for R17. Interviewed staff (S) 39 who confirmed that R17 did not have a current risk assessment or informed consent for bed rail use completed for this admission. Showed S39 the definition of what a bed rail is from the revised Appendix PP (November 28, 2017) which states "Bed rails" are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Also some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of the bed. Examples of bed rails include, but are not limited to: side rails, bed side rails, and safety rails; and grab bars and assist bars. S39 was not aware of this definition of bed rails and stated that she was using a "manual dated October 2017." S39 showed her manual with the stated date.	4 136		
4 185	11-94.1-46(b) Pharmaceutical services (b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and director of nursing that: (1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions	4 185		7/31/18

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4 185	Continued From page 8 and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs; (2) Is reviewed at least every two years and revised as necessary to keep abreast of current developments in overall drug usage; and (3) Has a drug recall procedure that can be readily implemented. This Statute is not met as evidenced by: Based on observation and staff interview the facility failed to ensure two inhalers had the opened on date and discard by dates written on pharmacy provided labels after these medications were opened. Findings Include On 06/28/18 at 10:05 AM while going through medication storage and looking through the medication cart on the Laulima unit with Staff (S) 50 found an inhaler, Stiolto Respimat, for Resident (R) 19 with sticker placed on the medication box which stated "Discard after" and an unidentified staff wrote the opened date of "6/1/18". When queried S50 stated this was an error and that the discard date of three months (after insertion of the cartridge into inhaler) should have been written there. A second inhaler was Combivent Respimat 20 mcg/100 mcg which had a sticker that had a blank date opened and discard by date, this sticker was not filled out. Unidentified staff had written in black ink R26's last name and opened date 6/10/18 on the inhaler itself.	4 185	4185 11-94.1-46(b) Pharmaceutical Services: Specific Residents: Medication inhalers for Residents R#19 and R#26 were immediately labeled with discard after date. Other Residents: Medication carts will be audited to ensure that inhaler medications are appropriately labeled with an opened on: date and a discard after date on pharmacy provided labels in accordance with pharmacy guidelines. Systemic Changes: The DNS or Designee will in-service nursing staff per pharmacy guidelines to ensure appropriate labeling of inhaler medications. Nursing is to follow manufacturer guidelines noted on medication unless pharmacy indicates otherwise. Monitoring:	

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4 185	Continued From page 9 Review of facility policy "Medication Administration" did not find any procedures or guidelines on how to label the opened on dates and discard by dates of medications such as inhalers.	4 185	DNS or Designee will audit medication carts weekly for the next 3 months to ensure appropriate labeling is in place. Any identified issues will be corrected. Results of the audits will be reported to QAPI monthly for 3 months. Responsible Person: The DNS will be responsible for ongoing compliance. Date of Correction: Compliance will be met by 7/31/18 and on an ongoing basis.	
4 220	11-94.1-55(g) Housekeeping (g) All combustible, potentially hazardous, or poisonous agents used for the cleaning of the facility shall be stored in a secured and locked area. This Statute is not met as evidenced by: Based on observation, and staff interview the facility failed to ensure that the resident environment remains free of accident hazards. The deficient practice left 17 residents housed on the unit access to toxic chemicals. The facility failed to ensure toxic chemicals were secured from residents' access. The relative risk to each resident housed in the unit is individual, but there were at least two groups whose level of cognitive impairment placed them at greater risk than residents that were assessed as cognitively intact. Findings include: During a tour of the laundry room on 06/28/18	4 220	4220 11-94.1-55(g) Housekeeping: Specific Residents: The Laundry Room access doors immediately secured with key only access. Signs posted □for the safety of our residents this door to remain locked at all times. Other Residents: Other areas where chemicals are kept were reviewed to ensure appropriately stored and locked. Systemic Changes: The Maintenance Supervisor will	7/31/18

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4 220	Continued From page 10 09:59 AM with Staff (S) 24 it was observed that S24 accessed the room without a key. Upon entry to the room, there were four bottles of bleach stored on the lowest tier of a multi-tiered shelf. S24 was asked if the room is secured, to which S24 replied no. S24 was asked if residents on the Lokahi unit could access this room, to which S24 replied yes. S24 confirmrd that the bottles marked "bleach" did in fact contain bleach. It was visually confirmed that the laundry room could be secured with key only access. S24 was asked if other laundry staff had a key to the laundry room to which he verbalized only he had a key to the laundry room. During an interview on 06/28/18 at 02:37 PM with S22 confirmed that all residents housed in the Lokahi unit could ambulate with either a walker or wheelchair. The Brief Interview for Mental Status (BIMS) is a standardized cognition test with the following categories; severe cognitive impairment, moderate cognitive impairment, and cognition intact. Record review of residents housed on the unit reflected that Resident's (R) 2, R13, R30, R40, R42, and R48 were assessed at severe cognitive impairment, R22, R31, R33, and R37 were assessed at moderate cognitive impairment, while the remaining seven residents housed on the unit were assessed at being cognitively intact.	4 220	in-service staff regarding prevention of resident access to toxic chemicals and ensuring laundry room is locked. Housekeeping and laundry staff in-serviced by Maintenance Director on securing of access of toxic chemicals to assure facility and resident safety. Monitoring: Maintenance Supervisor will audit chemical storage for security weekly for the next 3 months to ensure compliance. Any identified issues will be corrected. Results of the audits will be reported to QAPI monthly for 3 months. Responsible Person: The Maintenance Supervisor will be responsible for ongoing compliance. Date of Correction: Compliance will be met by 7/31/18 and on an ongoing basis.	