Hawaii Dept. of Health, Office of Health Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

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4000	Initial Comments A re-licensure survey was completed from 07/24/2018 to 08/02/2018. At the time of the entrance conference, the resident census was 109.	4000		
4105	11-94.1-22(g) Medical record system (g) All entries in a resident's record shall be: (1) Accurate and complete; (2) Legible and typed or written in black or blue ink; (3) Dated; (4) Authenticated by signature and title of the individual making the entry; and (5) Written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical doctor. This Statute is not met as evidenced by: Based on medical record (MR) review and staff interview the facility failed to complete the "Interfacility Communication for HEMODIALYSIS Residents" form for resident (R) 32 prior to R32 having dialysis service on 07/28/18. The facility failed to communicate to the dialysis center the patency of R32's vascular access site, R32's condition or complaints and name and title of nurse filling out the communication form. The facility failed to closely monitor R73 post fall by not completely documenting R73's neuro checks	4105	The Director of Nursing (DON), Nursing Supervisors (SRN), Head Nurses (HN) and Education nurse will implement corrective action for R32 affected by this practice, including: 1) The SRN and HN counseled and re-educated the LN in question on the importance and expectation of completing the Inter-facility Communication form for hemodialysis residents prior to the residents hemodialysis. Review of the policy on Guidelines for Nursing Care of the Hemodialysis Resident was also completed. (8/31/18) 2) The SRN/HN counseled and re-educated the LN in question on the facilitys P&P on neuro-checks post-falls and post-fall monitoring. (8/31/18) The DON, SRN, HN, and Education nurse will assess all residents having the potential to be affected by this practice, including: 1) The SRN and HNs identified all three residents in the facility receiving hemodialysis to have an Inter-facility Communication form completed prior to leaving for hemodialysis procedure and identify LNs who are not completing the forms to be counseled as necessary.	9/12/18

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TITLE: Electronically Signed

(X6) DATE: 9/5/2018

Violeta K. Ego, NHA, Administrator

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4105	Continued From page 1 and vital signs on the Nursing Observation Flowsheet for 72 hours post fall. Findings include: On 08/01/18 at 01:05 PM while reviewing R32's MR with LN7 noted that the "Interfacility Communication for HEMODIALYSIS Residents" form dated 07/28/18 was missing "checked patency prior to transfer" the box was left blank, "Condition/Complaints:" was left blank and "Name of Nurse/Title (print)" was also left blank. Inquired with LN7 if this was supposed to be filled out and she concurred, stated that staff were supposed to have filled out the information before R32 went to dialysis appointment. Requested and was given the facility's policy on "Guidelines for Nursing Care of HEMODIALYSIS Resident/Patient." Review of facility's policies and procedure, "Guidelines for Nursing Care of HEMODIALYSIS Resident/Patient", found under III. Procedure E. 1 c. Complete "Inter-Facility Communication" sheet prior to transport and fax to the dialysis center. 2) On 08/02/18 at 09:53 AM during MR review noted R73 had fallen on 05/04/18 and was to have been monitored closely for any changes in clinical condition for 72 hours as stated on facility "Nursing Observation Flowsheet." R73's "Nursing Observation Flowsheet", dated "5/4/18" was not completely filled out. The neuro check (level of consciousness (LOC), pupils, grasps), range of motion (ROM), pain level/site, initials and title were left blank from "1520", "1535", "1605", "1635", "1735", "1835" and "2235." Noted on "5/7/18" at "0535" the temperature, pulse, respirations, blood pressure, O2 saturation, neuro checks, ROM, pain level/site	4105	(8/31/18) 2) A review of all residents records with falls for the past 6 months will be conducted to ensure post fall monitoring were completed per facilitys post-fall P&P.(9/12/18) The Education nurse or DON and SRN will implement measures that this practice does not recur, including: 1) The Education nurse or DON and SRN will inservice all LNs on the policy and procedures on the Guidelines for Nursing Care of the Hemodialysis Resident and review the importance and expectation of completing the Inter-facility Communication form and faxing it to the hemodialysis center prior to treatment of hemodialysis resident. (9/12/18 and on-going) 2) The DON / SRNs will conduct a review to all LNs on P&P of post-fall monitoring including neurochecks and the importance of keeping a complete, accurate, and timely documentation of residents post-fall monitoring and observations. (9/12/18) The DON, SRN, Education nurse and QA will monitor corrective actions to ensure the effectiveness of these actions, including: 1) The SRN, HN, LN, DON, and/or her designee to conduct a follow-up check to ensure this process is taking place prior to each residents hemodialysis procedure. (9/12/18) 2) The SRN, HN, LN, DON, and/or her designee will continue to monitor LNs to	

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4105	Continued From page 2 and initials and title were left blank. Interviewed LN7 and inquired if a licensed staff was working on 05/04/18 from 3:00 PM to 11:00 PM and she confirmed there was one licensed staff working evening shift with 31 residents. Inquired if this "Nursing Observation Flowsheet" was supposed to be completely filled out and she confirmed this. Requested facility policy regarding Neuro Checks after falls and LN7 provided the "Post Falls Monitoring" policy and procedure. Review of facility's Post Fall Monitoring policies and procedures found "Procedure 4. a. Continue monitoring resident's condition for the next 3 days and document status in the medical record... b. Vital signs, including pain score, (neuro checks if there is any possibility that resident may have struck head) as follows: Every 15 min. for first hour; if stable then every 30 min. x 2; if stable then every hour x 2; if stable then every 4 hours x 5; if stable then every 8 hours x 2 days."	4105	ensure that neurochecks and post-fall monitoring are completed every time there is a fall (9/12/18) 3) The results of this follow-up checks will be reported to QAPI for further actions and recommendations as needed. (9/12/18 and on-going)	
4149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference;	4149	The Director of Nursing (DON), Head Nurses (HN), Interdisciplinary Team (IDT) and Minimum Data Set (MDS)Coordinators will implement corrective action for R69, R32 and R73 affected by this practice, including: 1) The DON, Head Nurses (HNs),Interdisciplinary Team (IDT) and Minimum Data Set (MDS) Coordinators will ensure that each section of the MDS assessments accurately reflect each residents' status.(8/31/18) 2) For R69, the HN and MDS Coordinators reviewed and modified section "H" Bowel and Bladder to accurately reflect that resident has only an indwelling Foley	9/12/18

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4149	Continued From page 3 (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on staff interview and medical record (MR) review, the facility failed to accurately assess and record three Residents' (R) 32, R69, and R73 Minimum Data Set (MDS) out of 33 residents selected for review. The facility failed to accurately assess and record R69's medical condition and status and R32 and R73's bed rail use at the time of the assessment. Each portion of the MDS assessment must accurately reflect the resident's status as of the Assessment Reference Date (ARD). Findings include: 1) On 07/31/18 at 8:34 AM MR review of R69's MDS with ARD of 09/07/17 showed discrepancy noted in section: "H" Bladder and Bowel under A. Indwelling catheter, and B. External (condom) catheter, both areas were checked off. R69 is a female, part B. External (condom) catheter would not apply to R69. During interview with MDS Licensed Nurse (LN) 5 on 07/31/18 at 8:40 AM regarding R69's admission MDS with ARD of 09/07/17 under section "H" Bladder and Bowel, both "Indwelling catheter" and "External (condom) catheter" were checked off, MDS LN5 stated it appears it was coded incorrectly but will look into it and let	4149	catheter and does not use an external condom catheter.(8/31/18) 3) For R32, and R73, the HN and MDS Coordinators reviewed and modified the MDS Assessments to reflect the fact both residents were using bed rails for turning and repositioning based on their care plans. Both residents have signed informed consents and release forms for side rails as well as signed risk assessments.(8/31/18) The DON, HNs, MDS Coordinators and IDT will assess all residents having the potential to be affected by this practice, including: 1) The DON, HNs, IDT and MDS Coordinators will identify those residents with indwelling Foley catheters to ensure accuracy of the MDS section and reflected in their care plans.(9/12/18) 2) For all those residents who are currently using bed rails for bed mobility and other reasons will be identified and re-assessed and referred to Rehab therapist to evaluate other devices that are least restrictive.(9/12/18) The DON, Nurse Supervisors (SRN), HN and IDT will implement measures to ensure this practice does not recur, including: 1) The DON and Quality Assurance (QA)Manager will review and re-inservice the MDS Coordinators to ensure they understand that assessments must be accurately completed to reflect the current	

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4149	Continued From page 4 surveyor know later. Interview on 07/31/18 at 8:49 AM with MDS LN5 who stated the admission MDS with ARD of 09/07/17 for R69 under section "H" Bladder and Bowel was coded (recorded) incorrectly. MDS LN5 stated she was not the original staff who coded the admission MDS (09/07/17) but admitted she overlooked section "H" Bladder and Bowel during her quarterly MDS review. MDS LN5 stated she has made the correction and submitted the modification into MDS. 2) On 08/01/18 at 02:30 PM MR review found that R32 signed a Side Rails Informed Consent and Release form on 06/14/18 and noted that it states "X 2 side rails." R32 also had a Restraint Device Assessment and Care Assessment Area (CAA) review form in the electronic medical record dated 08/24/17. Noted that R32's last Minimum Data Set (MDS) quarterly assessment dated 05/03/18 was coded that bed rail was "not used." On 08/01/18 at 02:48 PM interviewed licensed nurse (LN) 8. Inquired why R32 was coded in MDS quarterly assessment dated 05/03/18 as not using bed rails and R32 has bed rails on her bed. LN8 stated it was an error, confirmed that R32 should have been coded for bed rail use in last MDS quarterly assessment dated 05/03/18 and stated that she will modify this. 3) On 08/02/18 at 09:33 AM R73 was observed with bilateral upper grab bars on his bed. MR review of R73's MR found that R73 had a risk assessment dated 06/03/18 and a consent for bed rail use dated 06/14/18. R73's quarterly MDS dated 06/07/18 was not coded for R73's use of side rails (grab bars). MR review found that R73 has a care plan in place for use of grab	4149	overall status of the residents.(9/12/18) 2) During weekly care plan conferences, the DON, SRN, HN and the IDT will double-check all entries in the MDS' prior to submittal to CMS.(9/12/18 and on-going) The DON, SRN, and QA will monitor corrective actions to ensure the effectiveness of these actions, including: 1) The DON, SRN and QA will initiate a quality monitoring program to randomly check MDS assessments on a monthly basis and as needed to ensure continuous quality monitoring is implemented effectively and will be reported to the QAPI committee for discussion/recommendations.(9/12/18 and on-going) The Director of Nursing (DON), Nursing Supervisors (SRN), and Head Nurses (HN)will implement corrective action for R44and R310 affected by this practice, including: 1) The DON, SRN, HN and interdisciplinary team (IDT) immediately reviewed the facility's admission process to ensure baseline care plans (BCP) are developed and implemented within 48 hours for each resident admitted to the facility.(8/31/18) 2) The SRN and licensed nurses in question for R44 and R310 were re-educated and counseled on the facility's policy and procedure on the importance of completing and implementing a baseline care plan within 48 hours of admission and the potential effect of this necessary medical information to properly care for	

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4149	Continued From page 5 bars for bed mobility/turning. On 08/02/18 at 09:45 AM interviewed MDS LN6 and she concurred R73 does have bilateral upper grab bars on his bed and concurred that R73 should have been coded for bed rail use in the quarterly MDS dated 06/07/18. MDS LN6 stated this will be modified. Based on staff interview and medical record (MR) review, the facility failed to complete and implement the baseline care plan within 48 hours of resident's admission for two Residents (R) 44 and R310 out of 33 residents selected for review. This had the potential to affect the necessary medical information to properly care for R44 and R310, immediately upon their admission, which would address resident specific health and safety concerns to prevent decline or injury, such as Falls or elopements. Findings include: On 07/30/18 at 10:09 AM medical record (MR) review found R44 was admitted to the facility on 05/08/18. R44's baseline care plan (CP) was signed by both nurse and R44 and dated 05/17/18. It was noted that the baseline CP for R44 was created and implemented nine days after R44's admission to the facility. Interviewed LN7 who confirmed baseline care plans are to be created and implemented within 48 hours of admission to the facility. Review of facility's Nursing Services Memorandum Subject: "Interim" Care Plan CHANGE to "Baseline" Care Plan states under Procedure: 2. The unit's licensed nurse who is admitting the resident will initiate the Baseline Care Plan... 3. The evening and night shift licensed nurses	4149	that could prevent decline or injury to these residents.(8/31/18) The DON, SRN, HN, Education nurse and IDT will assess all residents having the potential to be affected by this practice, including: 1) The DON, Education nurse, SRNs, HNs, and IDT will audit all medical records of new admissions within the past 6 months to ensure that BCP are completed and implemented within 48 hours of admission.(9/12/18) The DON, Education nurse, SRN, HN and IDT will implement measures to ensure that this practice does not recur, including: 1) The DON, Education nurse, SRNs, HNs, and IDT will review and update existing Admission checklist policies to include the completion of a baseline care plan within 48 hours of admission. An alert will be generated in the residents' electronic health record for licensed nurses to complete and implement a BCP for each new admission in a timely manner (9/12/18) 2) All newly hired licensed nurses (SRNs, HNs, RNs, LPNs) will be in-serviced/re-educated on the admission process/checklist as well as the requirements for all residents admitted/re-admitted on developing timely BCPs and implemented within the 48hour of resident's admission.(9/12/18 and on-going) The DON, Administrator, SRNs, HNs, and	

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4149	Continued From page 6 will complete the rest of the form within 48-hours of admission (requirement). 4. Head Nurses will ensure the Baseline Care Plan is completed by all shift. 2) On 08/02/18 at 11:29 AM MR review of R310's "Interdisciplinary Admission Care Plan" showed two areas of the care plan checked, 1) "Requires Adjustment to Facility related to new admission/readmission" and 2) "Falls." There were no signatures and/or dates noted to this care plan. During interview with LN1 on 08/02/18 at 12:35 PM, LN1 concurred there were no signatures and/or dates noted to the "Interdisciplinary Admission Care Plan" for R310. LN1 stated the "Interdisciplinary Admission Care Plan" was done within 48 hours of R310's admission and should have been signed and dated by staff who initiated this care plan.	4149	IDT will continuously monitor to ensure the effectiveness of these corrective actions, including: 1) The SRNs, HNs, and LNs will audit new admissions medical records weekly to ensure that all new admissions have a BCP developed and implemented within 48 hours of admission.(9/12/18 and on-going) 2) The DON and QA manager will review findings and report to QAPI for follow-up actions and recommendations as necessary.(9/12/18 and on-going)	
4174	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 medical record (MR) review and staff interview the facility failed to develop a care plan (CP) for residents (R) 56 dental care for cavity. The facility failed to create and implement a CP to notify the dietitian of a six pound (lbs) weight gain for R32 who is receiving hemodialysis.	4174	The Director of Nursing (DON), Nursing Supervisors (SRN), and Head Nurses (HN)and IDT will implement corrective action for R33 affected by this practice, including: 1) Immediately after being informed of the concern regarding R33s mouth with foul odor, SRN and HN met with the LN and CNA assigned to this resident. Upon observation during residents oral care, the following was noted: Staff had difficulty keeping residents mouth open. Because of his diagnosis of anoxic brain damage, resident has no control and tends to clench teeth and keep mouth tightly closed. The LNs/CNAs were provided with a bite stick used for residents with this condition. As of this time, staff was able to keep his mouth	9/12/18

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4174	Continued From page 7 Findings include: 1) On 07/26/18 at 01:05 PM During interview with R56 who reported she has a cavity on the upper right side of her mouth and has not seen a dentist. R56 stated she cannot transfer to the dental chair if she was taken to the dentist office. On 07/27/18 at 04:06 PM MR review found R56 was seen on 06/03/18 by the dentist, who came to the facility. The consulting dentist stated R56 has a cavity and recommended tooth extraction. He also recommended that all of R56's teeth be extracted to prevent future dental issues. On 07/30/18 at 09:20 AM interviewed Licensed Nurse (LN) 7 who stated she spoke with R56 on 07/27/18 regarding the dental consult recommendations. LN7 stated R56 will inform staff if she has pain or wants to pull out all of her teeth. CP was expanded to include "Oral/dental health problems r/t teeth carious" on 07/30/18 after LN7 discussed dental consult recommendations with R56. 2) On 08/01/18 at 11:54 AM MR review found R32 has a diagnosis of End Stage Renal Disease dated 12/07/18 and Dependence on Renal Dialysis dated 12/07/18. Review of R32's MDS dated 05/03/18 has R32 coded for dialysis services. MR review found that R32 has a CP in place for hemodialysis which includes interventions such as diet ("Renal, Heart Healthy"), fluid restriction of 1000 milliliters (ml) per day and notify Registered Dietitian (RD) of five pounds gain or loss within a month. Review of daily fluid intake for R32 was less than 1000 ml.	4174	care. Current oral hygiene has improved dramatically. (8/31/18) 2) The HN and LN obtained a physicians order to administer via G-tube Body Mint tablets as to supplement for body odor and no further examination of resident was necessary at this time.(8/31/18) 3) R33s Care plan was reviewed and revised. (8/31/18) 4) The HN & LN will ensure all treatment orders and interventions are accurately carried over to the next months treatment records until the problem is resolved (9/1/18) 5) A follow-up dental consult will be scheduled to further evaluate current oral care, dental status and a plan for a dental hygienist to remove plaque.(9/12/18) The DON, SRN, HN, and LN will assess all residents having the potential to be affected by this practice, including: 1) A facility-wide assessment of all residents oral status especially those who were examined by facilitys dental consultant or residents private dentists will be conducted to ensure development of care plans addressing any oral care issues or any dental problems.(9/12/18) 2) All residents records, Medication Administration Records (MARs); and Treatment Administration Records (TARs) will be reviewed to ensure accurate transcription of orders / interventions are carried out to next months records until	

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4174	Continued From page 8	4174	issues are resolved. (9/12/18 and on-going) The DON, SRN, HN, and Education nurse will implement measures that this practice does not recur, including: 1) A mandatory inservice for all LNs and CNAs on the importance of good oral hygiene, especially for total dependent residents.(9/12/18) 2) Consult with the facility's dental consultant on techniques and practices to better provide good oral hygiene to all residents especially those residents with challenging oral issues.(9/12/18 and on-going) 3) HN and LNs will promptly review dental consultation reports to ensure areas of concerns found with consultants' recommendations are carried out promptly and CPs are revised as necessary (9/12/18 and ongoing) 4) HN, SRN and LNs will maintain a regularly scheduled appointment bi-annually or more often as needed for follow-up with the dentist for residents found with oral/dental issues.(9/12/18) 5) The DON, HN and SRN will meet with the LNs/CNAs on a regular basis to ensure problems or concerns during care, i.e., difficulty with keeping mouth open during oral care_ can be discussed and addressed promptly. Use of the Stop and Watch communication tool will be re-enforced. (9/12/18)	

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4174	Continued From page 9	4174	6) SRN / HN will double check MAR / TAR orders to ensure all orders and interventions are carried over to the next months records (9/12/18 and ongoing). The DON, SRN, HN, and IDT will monitor corrective actions to ensure the effectiveness of these actions, including: 1) HN and LNs for each unit will perform daily rounds to ensure good personal hygiene is maintained on all residents, and also to ensure all current orders are carried over to next months MAR / TAR until the issues are resolved.(9/12/18 and ongoing) 2) Results of this monitoring will be reported to QAPI and actions / recommendations will be implemented as necessary (9/12/18 and ongoing) The Director of Nursing (DON), Nursing Supervisors (SRN), and Head Nurses (HN) will implement corrective action for R56 affected by this practice, including: 1) Immediately after hearing R56s concern, SRN and HN developed a care plan to address R56s dental problem. According to the dental consultant, her remaining teeth will need to be extracted to prevent further dental issues. However, when R56 was informed of the situation, she refused to follow the dentists recommendation. A follow-up consultation is being scheduled with R56 and family to further discuss.(8/31/18) The DON, SRN, HN, licensed nurses (LN)and interdisciplinary team (IDT) will assess all residents having the potential to	

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	125010	A. BUILDING _____ B. WING _____	C 08/02/2018

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4174	Continued From page 10	4174	affected by this practice, including: 1) Identify all other residents and develop care plans for those with poor oral hygiene and/or have oral / dental issues or problems identified during routine dental examinations conducted by dental consultant.(9/12/18) The DON, SRN, HN, and LNs will implement measures that this practice does not recur, including: 1) During the weekly care plan conference, the IDT will ensure to interview residents, families and their care givers (LN and CNAs) on resident care including issues concerning oral care.(9/12/18 and on-going) 2) LNs and nurse aides (CNA) will be in-serviced to immediately report any observations affecting resident care using the Stop & Watch communication tool.(9/12/18) 3) A CP will be developed for any problems or concerns regarding resident care including oral care.(9/12/18) The DON, SRN, HN, LN, and Dietician (RD) will monitor to ensure the effectiveness of these actions: 1) The DON, SRN, HN, LN, and Dietician (RD) will continue to monitor all residents oral status daily to ensure any issues / concerns will be addressed promptly and a CP will be developed(9/12/18 and on-going)	

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4174	Continued From page 11	4174	2) The results of this QA will be forwarded to QAPI for recommendations as necessary.(912/18 and on-going) The Director of Nursing (DON), Nursing Supervisors (SRN), Head Nurses (HN), and Dietitian (RD) will implement corrective actions, including: 1) HN, SRN, LN, and RD was informed of the 6lb weight gain from the previous months. Measures were implemented to ensure any weight gain/loss noted for R32will now be reported to RD immediately. Care plan has been reviewed with RD as well as with the LNs on this unit.(8/31/18) 2) R32s hemodialysis care plan was reviewed with all staff on each shift.(8/31/18) 3) Current weight from last month to this month was reviewed with RD: No weight gain nor weight loss was noted.(8/31/18) The DON, SRN, HN, LNs, and RD will assess residents having the potential to be affected by this practice, including: 1) Identify all residents in the facility who are undergoing hemodialysis to ensure that their care plans properly address requirements for immediate reporting of changes such as weight gain/loss and other potential complications related to hemodialysis.(9/12/18) The DON, SRN, HNs, LNs and RD will implement measures to ensure this practice does not recur, including:	

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4174	Continued From page 12	4174	1) HN, LNs, and RD will review residents weights on a weekly basis especially for those receiving hemodialysis for any weight gain/loss.(9/12/18 and on-going) 2) All LNs and CNAs will be re-educated on the existing policy on the care of the hemodialysis residents and to observe, monitor and report any complications they may have.(9/12/18) 3) Use of the Stop & Watch communication tool will be reinforced to report any weight changes or other observed issues especially with hemodialysis residents.(9/12/18 and on-going) 4) Monthly audit on weights for residents on hemodialysis will be conducted by the RD to ensure a care plan is developed and interventions are implemented in a timely manner as necessary. (9/12/18 and on-going) The DON, SRN, HN, RD, QA, Administrator and IDT will monitor corrective actions to ensure the effectiveness of these actions, including: 1) The DON and QA will ensure the continuous quality monitoring program in this area of resident care is in place and effective. Results of the monitoring program will be reported to QAPI for further actions and recommendations as necessary. (9/12/18 and on-going)	

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE