Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING: ______ B. WING ______	08/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

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4 000	Initial Comments A state licensure survey was conducted on 08/21/18 to 08/28/18. Census at the time of entry was reported as 105.	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 observation, record review, staff interview and review of facility policy the facility failed to place a pillow between resident's feet to prevent pressure on her feet putting her at risk for developing a pressure ulcer (PU) on her feet. Resident (R73) was one of six residents selected for review. This deficient practice had the potential to affect the 4 residents identified by the facility to have pressure ulcers. Findings Include: On 08/22/18 at 10:06 AM during record review (RR) of R73's electronic medical record (EMR)	4 136	HEAD NURSE (HN), LICENSED NURSES (LN), CERTIFIED NURSE□S AIDE (CNA), AND INTERDISCIPLINARY TEAM (IDT) WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT #73 AFFECTED BY THIS PRACTICE, INCLUDING: 1) HN and LN educated all CNAs assigned to resident#73 the importance to follow the plan of care to prevent skin breakdown and pressure injury by reviewing the following: Place pillows in between feet and check for proper placement to keep pressure off between	10/12/18

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/26/18

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4 136	Continued From page 1 noted R73 had documentation of "recurrent open area on her right big toe" dated 06/18/18. Reviewed R73's skin assessment dated 08/14/18 at "1304" found there was a PU that was unstageable that was acquired in facility. On 08/27/18 at 11:14 AM at R73's bedside, with licensed practical nurse (LPN)1, requested to see R73's right foot. LPN1 pulled back R73's blanket and sheet noted R73's right big toe was healed. LPN1 stated "I will put a pillow" when it was discovered that R73's feet were resting near each other, side by side, touching each other. Further RR found PU documentation on 08/14/18 stated PU was "new" but at bottom of documentation it stated under notes "Wound RN assessed and seen-resolved." Record review (RR) found R73 coded for a stage 2 PU on her last annual Minimum Data Set (MDS) dated 07/10/18. It was noted on R73's care plan (CP) that she is at risk for skin breakdown due to vegetative state, incontinence and diabetes. R73's CP was in place for PU wound and foot care but no intervention listed to place a pillow between feet to prevent the development of a PU. On 08/27/18 at 11:55 AM interviewed Head Nurse (HN) 2 who stated staff should be placing a pillow between reidents feet to prevent putting pressure on the foot/feet. Review of facility Skin Care and Pressure Injury Prevention policy stated "D. Protection from Friction, Shear and Pressure 6. Use positioning wedges or pillows. 7. Suspend heels while in bed." Neither of these were done for R73 upon observation 08/27/18 at 11:14 AM, putting this resident at risk to develop another PU on her feet.	4 136	feet, check placement of pillows during turning and repositioning as it can be displaced, float heels off of bed by placing pillows under calves, apply Prevalon boots & check every shift for proper placement/positioning and circulation, keep the skin soft and smooth apply a thin layer of skin lotion over the tops & bottoms of the feet but never between the toes. (Completed 08/29/18) 2) IDT reviewed and updated resident's care plan to address prevention of skin/pressure injury. (Completed 09/17/18) HEAD NURSE (HN), LICENSED NURSES (LN), CERTIFIED NURSE□S AIDES (CNA), AND INTERDISCIPLINARY TEAM (IDT) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING: 1) Residents who are at risk for developing skin breakdown and pressure injury, such as with history of pressure ulcer and/or with contractures, will be identified. IDT will review and update their care plans to address prevention of skin breakdown and prevention of recurrence of pressure-related issues. (Start 09/17/18 / On-Going) HEAD NURSE (HN), WOUND NURSE (WN), LICENSED NURSES (LN), CERTIFIED NURSE□S AIDE (CNA), AND INTERDISCIPLINARY TEAM (IDT) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: 1) HN and LN will educate the CNAs regarding the importance of prevention of	

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4 136	Continued From page 2	4 136	skin breakdown / pressure injury and identifying residents at risk, during shift reports.(Completed 09/07/18) 2) CNAs will follow residents documented care plan. (Start 09/07/18 / On-Going) 3) HN will ensure that RAI/IDT will develop/review/update care plans based on the residents risk identified. (Start 09/17/18 / On-Going) 4) LN will follow the Skin Care and Pressure Injury Prevention P&P which includes performing weekly skin assessments and reporting to HN/WN all new skin issue/wound injuries; taking digital photo and documenting assessments for all new wounds; taking weekly digital photos of skin injuries until healed; assessing and carrying out appropriate treatment recommendations for wound management; monitoring progression of healing or non-healing; and reporting findings to HN, WN and MD for change in treatment. (Start 09/17/18 / On-Going) 5) WN will compile and distribute Weekly Wound Worksheet to DON, HNs, SRNs, RAIs, and Administrator. (Start 08/31/18 / On-Going) DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), HEAD NURSES (HN), LICENSED NURSES (LN), WOUND NURSE (WN) AND RESIDENT ASSESSMENT INSTRUMENT NURSE (RAI) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING: 1) DON, SRN, HNs, WN and LNs will do random check/monitoring of CNAs, do	

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4 136	Continued From page 3	4 136	visual bedside checks to ensure care plan is being followed. (Start 09/07/18 / On-Going) 2) New and recurrent pressure injuries/ulcers will be summarized monthly by the WN and HNs and reported to the Nurse Managers meeting. Summary of these reports will be reported to the quarterly Quality Assurance Performance Improvement (QAPI) committee for further discussion and appropriate interventions. (Start 10/01/18 / On-Going) 3) RAI and HN will include pressure ulcer prevention and treatment care plans in their monthly quality assurance (QA) audits. Audits will be submitted to the DON for review of any deficiencies. Findings of QA audits will be reported monthly at the Nurse Managers meeting and as needed to the quarterly QAPI committee for further discussions and recommendations for improvement. (Start 10/01/18 / On-Going)	
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 observation and staff interview the facility failed to maintain infection control precautions for two residents out of 40 residents	4 203	HEAD NURSE (HN) WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENTS AFFECTED BY THIS	10/12/18

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4 203	Continued From page 4 selected for review. Resident (R)8's open suction tubing with opposite end attached to suction canister was left on the bed side table. R73 had an open 0.9% Sodium Chloride (Normal Saline) container with an open date of "07/19" left at bedside with suction equipment was found on 08/28/18. The deficient practice had the potential to affect all residents who require suctioning at the facility. Findings Include: 1) On 08/21/18 at 08:30 AM observed R8's suction tube, leading from the suction canister, left on R8's bedside table and open end laying on top of the bedside table. On 08/21/18 at 09:45 AM inquired of HN2 if suction tube should be left open and on R8's bedside table and she concurred that suction tubing should not be left open on the bedside table. Later in the day, after lunch, HN2 stated that she changed out all of the suction attachments for all the residents on 2 Makai. 2) On 08/21/18 at 09:00 AM observed R73's bedside table with suction machine, tubing and normal saline. Noted that normal saline was open and dated "07/19." On 08/21/18 at 09:45 AM inquired of HN2 how long facility keeps open normal saline and she stated 24 hours. On 08/28/18 at 10:10 AM interviewed licensed practical nurse (LPN)2 who confirmed that she opened the 0.9% Sodium Chloride (Normal	4 203	PRACTICE, INCLUDING: 1) HN changed the tubing to the suction machine for resident#8. (Completed 08/29/18) 2) Resident#8 has not needed suctioning so suction machine was removed from bedside. (Completed 09/28/18) HEAD NURSE (HN) AND LICENSED NURSES (LN) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING: 1) Residents with suction machines were identified and tubing was checked to ensure it is properly covered. (Completed 09/28/18) DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), HEAD NURSE (HN), AND LICENSED NURSES (LN) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: 1) DON with HN and SRNs with input of Infection Control Nurse reviewed the Nasotracheal Suctioning Policy &Procedure (P&P). P&P was updated to include cleaning end of suction tubing with alcohol swab, wrapping end with sterile 4x4 gauze, and placing in 4x4 gauze packaging before storing. (Completed 09/28/18) 2) DON, SRN, and HNs will review with LNs how to properly clean, cover and store end of suction tubing as reflected in the revised Nasotracheal Suctioning P&P. (Completed 10/03/18) 3) HN and LN will remove used suction catheter after use, cleanse the suction	

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4 203	Continued From page 5 Saline) on "07/19" and stated that she used it one time for R73's g-tube dressing change to cleanse the site, dated thebottle "07/19" and accidentally left it at bedside. LPN2 stated that it was her fault that she forgot to throw it out. LPN2 confirmed that they only use and keep the normal saline for 24 hours once it is opened.	4 203	tubing end with alcohol swab, cover by wrapping with sterile 4x4 gauze, and place wrapped suction tube back into the 4x4 gauze package. (Start 10/03/18 / On-Going) DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), HEAD NURSE (HN), AND QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING: 1) DON, SRN and HN will do random checks to ensure updated P&P is being carried out and provide immediate feedback/correction as needed. (Start 10/03/18 / On-Going) 2) HNs will report on a monthly basis the findings of their audits to the Nurse Managers meetings. DON will summarize findings and report to the quarterly QAPI committee. (Start 10/01/18 / On-Going) HEAD NURSE (HN), NURSING SUPERVISOR (SRN), EDUCATION NURSE (EN) WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT #73 AFFECTED BY THIS PRACTICE, INCLUDING: 1) Expired solution (NS bottle) was removed from resident #73□s bedside. (Completed 08/29/18) 2) HN and SRN counseled, reviewed protocol/guidelines when to discard opened solution bottles after 24 hours and educated licensed practical nurse #2 identified /confirmed by initials written on NS bottle. (Completed 08/29/18)	

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4 203	Continued From page 6	4 203	3) EN reviewed Gastrostomy Tube Care and Special Expiration Requirement policies and procedures with licensed practical nurse #2. (Completed 09/19/18) HEAD NURSE (HN) AND LICENSED NURSES (LN) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING: 1) All residents□ bedside and treatment carts were inspected for expired solutions. No other expired solutions were found. (Completed 08/31/18) DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), HEAD NURSE (HN), LICENSED NURSES (LN) AND CERTIFIED NURSE□S AIDE WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING 1) DON, SRN and HN will educate licensed nurses regarding protocol/guideline to discard NS solution, sterile water after 24 hours of opening-during shift reports. (Completed 10/03/18) 2) HN and LN will do random check of bedside visual rounds. (Start 10/03/18 / On-Going) DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN), HEAD NURSE (HN), AND LICENSED NURSES (LN) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING: 1) HNs, and LN to do visual rounds of	

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4 203	Continued From page 7	4 203	resident□s bedside to ensure all solutions are discarded after 24 hours of date opened. (Start 10/03/18 / On-Going) 2) Expired open solutions at bedside will be added to list of things to be checked on the Medication Storage Inspection sheet/log. (Completed 09/28/18) 3) Audit is submitted daily at the end of shift to nursing office, nursing supervisors to summarize findings on a monthly basis. (Start 10/01/18 / On-Going)	
4 246	11-94.1-64(d) Engineering and maintenance (d) The facility shall maintain records that document that inspection of all devices essential to the health and safety of residents and personnel shall be carried out at sufficient intervals to ensure proper operational performance. This Statute is not met as evidenced by: Based on observation, staff interview, and review of facility policy, the facility failed to perform routine maintenance, based on manufacturer's recommendation, and failed to keep preventative maintenance records for two out of fourteen oxygen concentrators reviewed. This deficient practice put the residents at risk for the development and transmission of communicable diseases and infections. Findings Include: 1. During an observation and interview, on 08/21/18 at 2:30 PM, with staff RN3. RN3 stated the cleaning of all Oxygen Concentrator Filters were done on a weekly basis by the Certified Nursing Aides (CNA).	4 246	PURCHASING OFFICE AND NURSING WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENTS AFFECTED BY THIS PRACTICE, INCLUDING: 1) Reviewing the equipment manual for cleaning instructions. (Completed 08/29/18) 2) Creating a log for each nursing unit to document the cleaning of filters (outside cabinet filters) on a weekly basis. (Completed 08/29/18) 3) Creating a log for Purchasing Department to be completed at the end of every month to replace filters (outside cabinet filters). In addition, this log shall be used to document replacement of filters in between patient use. (Completed	10/12/18

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4 246	Continued From page 8 However, during an interview with CNA1 on 08/21/18 at 2:31 PM, CNA1 was unable to cite when and how the cleaning of the Oxygen Concentrator Filter was performed. During an interview with the Central Supply Manager (CSM) on 08/21/18 at 3:03 PM, CSM stated that the floor CNAs were the ones to do the cleaning of the Oxygen Concentrator Filters. However, CSM acknowledged that the facility did not keep a record of the cleaning and there was no way to verify that the Oxygen Concentrator Filters were being cleaned as recommended by the manufacturer. During a review of facility policy pertaining to the cleaning and disinfection of equipment, it stated that the cleaning and filter changing of the Oxygen Concentrator's will be done based on manufacturer's recommendations. The facility failed to perform that. During an interview with Director of Nursing on 08/28/18 at 09:00 AM, it was acknowledged that the manufacturer's recommendations for their oxygen concentrators were not being followed. Based on observation, staff interview, and review of facility policy, the facility failed to perform routine maintenance, based on manufacturer's recommendation, and failed to keep preventative maintenance records for two out of fourteen oxygen concentrators reviewed. This deficient practice put the residents at risk for the development and transmission of communicable	4 246	08/29/18) PURCHASING OFFICE AND NURSING WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING: 1) All residents with Oxygen concentrators were identified and filters (outside cabinet filters) were washed and logged. (Completed 09/05/18) 2) All Oxygen concentrators were sent to the Purchasing Office to replace the filter (outside cabinet filters) and logged. (Completed 09/11/18) PURCHASING OFFICE (PO) AND DIRECTOR OF NURSING (DON), NURSING SUPERVISOR (SRN) AND HEAD NURSES (HN) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: 1) Equipment manual for instructions on filter cleaning and logging requirements were reviewed with purchasing staff. (Completed 08/29/18) 2) DON, SRN and HN reviewed with nursing staff the requirement to wash filters weekly with soap and water, pat dry, replace back onto oxygen concentrator and to log cleaning was done. The weekly cleaning and logging will be done by day-shift licensed staff. (Completed 10/03/18) COMPLIANCE OFFICER AND QUALITY NURSE WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS,	

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4 246	Continued From page 9 diseases and infections. Findings Include: 1. During an observation and interview, on 08/21/18 at 2:30 PM, with staff RN3. RN3 stated the cleaning of all Oxygen Concentrator Filters were done on a weekly basis by the Certified Nursing Aides (CNA). However, during an interview with CNA1 on 08/21/18 at 2:31 PM, CNA1 was unable to cite when and how the cleaning of the Oxygen Concentrator Filter was performed. During an interview with the Central Supply Manager (CSM) on 08/21/18 at 3:03 PM, CSM stated that the floor CNAs were the ones to do the cleaning of the Oxygen Concentrator Filters. However, CSM acknowledged that the facility did not keep a record of the cleaning and there was no way to verify that the Oxygen Concentrator Filters were being cleaned as recommended by the manufacturer. During a review of facility policy pertaining to the cleaning and disinfection of equipment, it stated that the cleaning and filter changing of the Oxygen Concentrator's will be done based on manufacturer's recommendations. The facility failed to perform that. During an interview with Director of Nursing on 08/28/18 at 09:00 AM, it was acknowledged that the manufacturer's recommendations for their oxygen concentrators were not being followed.	4 246	INCLUDING: 1) Conduct monthly audit of the Nursing and Purchasing logs. (Start 09/30/18 / On-Going) 2) Conduct random quarterly audits of equipment by physically checking the outside filters. (Start 10/01/18 / On-Going) 3) Results of the audit will be shared with the Director of Nursing and summary reported to quarterly QAPI Committee. (Start 10/01/18 / On-Going)	