STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING: _____ B. WING _____	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET HILO, HI 96720

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4 000	Initial Comments A state re-licensure survey was conducted at the facility from 09/24/2018 - 09/27/2018. The facility's census was 223 residents at the time of entrance.	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 and staff interview, the facility failed to ensure residents were assisted to eat in a dignified manner for two residents (R) R53 and R177 during a lunch observation. This deficient practice affected two of 45 residents residing on the South 3 nursing floor. Findings Include: On 09/24/18 at 12:23 PM, a certified nurse aide (CNA) 1 was observed feeding R53 at her bedside. R53 requires feeding assistance. CNA1 however, stood over the resident to feed her. Each time CNA1 put a spoonful of food into R53's mouth, any excess pureed food or	4 115	Point 1 - How corrective action will be accomplished for those residents found to have been affected by the deficient practice. CNA 1, CNA2, and the Unit Manager received directed in-service training by the Director of Nursing which specifically addressed the necessity of maintaining resident dignity and rights during meal time. This instruction focused on sitting (not standing) and the proper cleaning of food spillage from mouth when assisting residents with dining.	11/11/18

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4 115	Continued From page 1 thickened liquid that came out of R53's mouth was swiped up. CNA1 used the spoon to quickly swipe up the excess food around the lower lip of the resident's face, and then re-inserted this excess food into the resident's mouth. At 09/24/18 at 12:24 PM, CNA1 also said, "I'm supposed to sit down, right?" and proceeded to sit on the right edge of the bed. After sitting on the bed, CNA1 began talking to the resident, saying short words to her such as, "We're almost done, juice, and okay, here." The resident was not able to reply. She was observed to utter illegible sounds. CNA1 repeatedly swiped around and re-inserted the food into R53's mouth until the resident no longer wanted to eat. On 09/24/18 at 12:31 PM, CNA2 was observed feeding another resident who required feeding assistance. CNA2 was standing to the right side of R177 to feed the resident her lunch. CNA2 engaged and talked with the resident during the meal, but did not sit down while she assisted R177 to eat. Yet, the nurse unit manager who was assisting R177's roommate to eat, sat on a chair next to her resident to feed her. During an interview with the Director of Nursing (DON) on 09/26/18 at 11:12 AM, she stated she preferred that her staff sat on chairs to feed residents who needed assistance to eat. The DON said she also wanted to see her staff engage their residents by talking to them, "Because they can hear." The DON said for any excess food coming out of a resident's mouth, "We wipe it with the napkin." She affirmed it should not be done by swiping excess food off of the resident's face and re-inserting it into their mouth for consumption. The DON acknowledged it was not a dignified way to feed any resident.	4 115	Point 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice; The Director of Nursing, or designee will review CNA charting in the EMR to identify all residents who require assistance with feeding. Point 3 - What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur; Direct care staff will receive directed in-service training regarding the proper feeding of residents to ensure resident dignity and rights are maintained. Point 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systematic changes. The Director of Nursing, or designee will review a random sample of at least 20 residents, who require assistance with feeding, weekly for a minimum of 30 days to ensure that resident dignity and rights are maintained during meal times. These reviews will cover all three meals and be conducted on various days and times. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) Meeting until the QAPI committee determines that further review is no longer necessary.	

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4 115	Continued From page 2	4 115	Point 5 □ Date Corrective Action will be Completed November 11, 2018	
4 118	11-94.1-27(7) 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: (7) The right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive; □ This Statute is not met as evidenced by: Based on staff interview and review of facility policy, the facility failed to establish sufficient policies and procedures that delineates the resident's right to formulate an advanced directive. This deficient practice had the potential to affect the 39 residents without a documented advance directive such that the residents may not be afforded the right to formulate an advance directive and/or the right to request, refuse, discontinue treatment, participate in or refuse to participate in experimental research. Findings Include: During a review of facility policy on Advance	4 118	Point 1 - How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Executive Director will be responsible for ensuring that the facility policy and procedure regarding Advanced Directives is current and addresses the areas identified in the 2567. Specifically, steps such as determining on admission whether a resident has an AD, identifying a primary decision-maker, and follow up procedures for residents who may have been incapacitated at the time of	11/11/18

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4 118	Continued From page 3 Directives (AD), the policy read, "The resident has a right to execute or refuse to execute an advance directive, which stipulates how decisions regarding his or her medical care are made. Residents have the right to self-determination regarding their medical care. This includes the right of an individual to direct his or her own medical treatment, including withholding or withdrawing life sustaining treatment. An advance directive is defined as a written instruction regarding care and treatment, such as a living will (a document that specifies a resident's preferences about measures used to sustain life) or a durable power of attorney for health care, recognized under state law in relation to the provision of such care when the resident is incapacitated. Community education and awareness efforts on the Patient Self-determination Act and state-specific laws on advance directives will be coordinated by the Social Services Director, using brochures in the facility lobby, public speaking, the Family Council, and health fairs." However, the policy did not mention any specific steps to assess, promote, implement, or evaluate the resident's right to formulate an AD. During an interview with the Social Services Director (SSD) 2, on 09/26/18 at 1:05 PM, SSD2 explained their current process for determining whether residents have ADs. SSD2 also explained how the facility provides education, material, and assistance with formulating an AD. The SSD2 said that ADs were also discussed during each resident's interdisciplinary group meeting. Although SSD2 was able to state what their current process was, it was not described in their current facility AD policy, and failed to include specific steps such as determining on admission whether a resident has an AD,	4 118	admission. Social Services audited all residents without a documented advance directive and verified that education has been provided. Point 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice; Social Services, or designee will review all residents to identify those residents without an advance directive. Point 3 - What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur; Social Services and the Interdisciplinary Team will receive directed in-service training on the facilities policy and procedure regarding advanced directives. Point 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systematic changes. The Social Services Director, or designee will be responsible for ensuring that the facility policy on advanced directives is implemented on each new admission and for each current resident. In addition, Social Services, or designee will review all residents without an advance directive weekly for a minimum of 30 days to ensure that all residents without an advance directive have been educated	

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4 118	Continued From page 4 identifying a primary decision-maker, and/or follow up procedures for residents who may have been incapacitated at the time of admission.	4 118	and given the opportunity to complete an advance directive. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) Meeting until the QAPI committee determines that further review is no longer necessary. Point 5 □ Date Corrective Action will be Completed November 11, 2018	
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 secure the soiled utility room located on the second floor. As a result of this deficient practice, the facility put the safety and well-being of the residents as well as the public, at risk for accident hazards. Findings Include: During an observation of the soiled utility room located on the second floor, north unit, on 09/24/18 at 10:46 AM, it was noted that the door, which had a number pad lock mechanism to enter the room, was not locked. As a result, anyone could have entered freely. No staff were observed in the immediate vicinity to prevent anyone from entering the room. There were no residents in the area at the time as well. The room had one large cart for soiled material, a	4 220	Point 1 - How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Upon identification of this concern, the Maintenance Director programmed the combination on the utility room door to ensure that it auto locks when closed. Point 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice; The Maintenance Director, upon notification of this concern, checked all utility doors to verify that the doors were locking appropriately upon closure. No further concerns noted.	11/11/18

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4 220	Continued From page 5 covered bin, another open bin for trash, a soiled utility sink, and chemicals for housekeeping/cleaning. On 09/24/18 at 10:54 AM, interviews with the Housekeeper (Hskpr 1) and the Manager (Mgr 5) were done. Hskpr1 and Mgr5 stated that the door to the soiled utility room should have been locked and secured. They acknowledged that the contents of the room had the potential to affect the safety of the residents, as well as the public, and further acknowledged the risk for accident hazards if it had been accessed. They then locked the soiled utility room.	4 220	Point 3 - What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur; All staff will receive directed in-service training on the necessity of ensuring that all utility rooms are locked when not in use and to report any future malfunctions immediately to maintenance. Point 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systematic changes. The Maintenance Director, or designee, will check all utility room doors at least weekly for a minimum of 30 days to ensure that the doors are locking appropriately upon closure. The reviews will be documented and the results will be presented to the QAPI Committee at each meeting until the QAPI determines that further review is no longer necessary. Point 5 □ Date Corrective Action will be Completed November 11, 2018	