STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125061	A. BUILDING: _____ B. WING _____	04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAUAI CARE CENTER	9611 WAENA ROAD WAIMEA, HI 96796

(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
4 000	Initial Comments A relicensing survey was conducted on April 15, 2018 through April 18, 2018 by the Office of Health Care Assurance (OHCA). Census was 49 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 observation, staff interview, and review of policy, the facility failed to identify potential accident hazards for the following: 1. Laulima Unit; exit door was not secured, 2. Central Supply Closet on the Laulima Unit was not secured. As a result of this deficient practice, the facility put the safety and well-being of the residents at risk for accident hazards. Findings Include: 1. During an observation of the Laulima Nursing Unit on 04/15/19 at 11:05, an exit door which	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. Tag 4136 Resident Care: SPECIFIC RESIDENTS Laulima unit door latch leading to outside storage area was immediately engaged and secured. The central supply closet	6/2/19

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4 136	Continued From page 1 contained a door latch, was not engaged and thus the door was not secured. The exit door lead to an outside storage area. During staff interview with Charge Nurse (CN) 59 on 04/15/2019 at 11:06 AM, CN59 stated that the exit door should have been secured at all times. A second staff interview with Staff Member (SM) 34 on 04/15/19 at 11:10 PM revealed that a staff member forgot to engage the door latch when re-entering into the facility. SM34 immediately checked that the door latch was engaged and that the exit door was secured. 2. During an observation of the Laulima Nursing Unit on 04/15/19 at 02:18 PM, the Central Supply Closet which had a door lock, was not locked and thus the closet was not secured. The closet contained various cleaning supplies including Spray Cleanse, Powder, Lotion, Skin Cream which contained various hazardous ingredients. During staff interview with Certified Nurse Aide (CNA) 36 on 04/15/19 at 02:22 PM, CNA36 acknowledged that the closet should have been locked. CNA36 also revealed that the locks were not always secured in the locked position and anyone could turn the lock to open it, even without the key. A second staff interview with CN56 on 04/15/19 at 02:34 PM revealed that CN56 was not aware of the locks not always being secured and that anyone could turn the lock to open it, even without the key. During a follow up observation of the Central Supply Closet on 04/17/19 at 11:00 AM, it was noted that the doors were secured with a different	4 136	was locked and secured. OTHER RESIDENTS Other exits/storage closets were reviewed to ensure they were secured. SYSTEMIC CHANGES Housekeeping and laundry staff in-serviced on securing the Laulima door leading to outside storage area. Signs posted for a reminder to staff. The lock was immediately replaced on the Central Supply closet and nursing staff educated to keep it locked. Central Supply closet was subsequently re-located thereafter to allow for keycode lock access. Nursing staff educated on keeping it secured. MONITOR The Maintenance Supervision/designee will audit the Laulima door leading to outside storage area and the central supply closet with daily rounds for 1 month, followed by weekly rounds to ensure security for the next 2 months. Any identified issues will be corrected and education provided as indicated. Trends identified through the audits will be brought to QAPI for 3 months to ensure ongoing compliance and identify need for further education and/or system revision. TITLE OF PERSON RESPONSIBLE FOR CORRECTION Administrator/Designee will be responsible for ongoing compliance. DATE OF COMPLIANCE Compliance will be met by 6/2/19 and on an ongoing basis.	

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4 136	Continued From page 2 combination padlock.	4 136		
4 149	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; (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 record review and interview with Staff (S)71, Director of Nursing, the facility failed to develop a care plan that incorporates all of the initial physician's orders within five days of admission for Resident (R)201. Findings Include:	4 149	Tag 4149 Nursing Services: SPECIFIC RESIDENTS Resident #201, the baseline care plan was updated to reflect care needs and to provide effective and resident-centered care.	6/2/19

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4 149	Continued From page 3 On 04/16/19 at 10:53 AM R201 complained of swelling in her lower legs. It was observed that R201 wore support stockings. It was also observed that R201was sleepy during the day which R201 validated as side effects of her psychiatric medications. On 04/17/19 at 12:00 PM Review of R201's records reflected that R201 is diagnosed with generalized anxiety disorder which supports the use of the Lorazepam, Amphetamine-Dextroamphetamine which are medications used to manage anxiety, diagnosed with major depressive disorder which supports the use of Duloxetine, an antidepressant and diagnosed with chronic diastolic congestive heart failure which supports the use of Furosemide which is used to manage swelling through increased urination. Review of R201's care plan did not include the Lorazepam, Amphetamine-Dextroamphetamine, Duloxetine, and Furosemide ordered by R201's physician. On 04/17/19 at 03:45 PM S71, the Director of Nursing reviewed R201's care plan and validated that the care plan did not include resident's prescribed Furosemide 60 mg by mouth, daily for fluid retention, Lorazepam 1mg by mouth at bedtime for anxiety, Duloxetine 60mg by mouth, daily for depression, Amphetamine-Dextroamphetamine 10 mg by mouth, daily for anxiety. S71 verbalized that she was aware that the facility is required to develop a care plan that incorporates all R201's initial physician orders within five days of admission and the facility did not develop such a care plan. S71 submitted an updated care plan for R201 for review after S71 was shown the deficient care plan.	4 149	OTHER RESIDENTS Residents who have not had a comprehensive care plan completed were reviewed to ensure the baseline care plan contain the minimum healthcare information necessary to properly care for the resident and updates made as indicated. SYSTEMIC CHANGES The DON or designee will in-service the interdisciplinary team and Licensed Nurses on CMS requirements for baseline care plan content. MONITOR The DON or designee will review baseline care plans for new admission(s) during the clinical meetings M-F to ensure the baseline care plans contain the minimum healthcare information necessary to properly care for the resident. Any needed changes will be made at that time and education will be provided as necessary. Trends identified through the audits will be brought to QAPI for 3 months to ensure ongoing compliance and identify the need for further education and/or system revision. TITLE OF PERSON RESPONSIBLE FOR CORRECTION Director of Nursing/Designee will be responsible for ongoing compliance. DATE OF COMPLIANCE Compliance will be met by 6/2/19 and on an ongoing basis.	

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4 159	Continued From page 4	4 159		
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 observations, staff interview, and review of policy, the facility failed to store the following foods under sanitary conditions: 1. B-B-Q Sauce, 2. Guava Jelly, 3. Ice in the ice machine. Findings Include: 1. During observation of the kitchen on 04/15/19 at 10:20 AM, a bottle of NOH Hawaiian B-B-Q Sauce had a label which read - Use by 3/10/19. Simultaneously during the above observation, Staff Member (SM) 55 was queried about the expired Use by date 3/10/19. SM55 acknowledged that this item should have been discarded on 3/10/19 as indicated on the label. 2. During observation of the kitchen on 04/15/19 at 10:22 AM, a bottle of Guava Jelly had a label which read - Use by 4/14/19.	4 159	Tag 4159 Storage and Handling of Food: SPECIFIC RESIDENTS No identified residents. The identified outdated food items were discarded. The zip lock bag of fish was immediately removed from the ice machine and the ice machine was immediately taken out of service, an out of service sign posted, and the ice machine was immediately cleaned and disinfected. OTHER RESIDENTS Residents have the potential to be affected by this practice and will be served meals in accordance with professional standards. SYSTEMIC CHANGES The identified staff member received 1:1 education and disciplinary counseling. Dietary staff were educated on dating food	6/2/19

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4 159	Continued From page 5 Simultaneously during the above observation, SM55 was queried about the expired Use by date 4/14/19. SM55 acknowledged that this item should have been discarded on 4/14/19 as indicated on the label. A review of the facility policy on Food Storage read the following: Policy; Dry food must be stored under sanitary conditions ... Procedure; Label with food name and the date when food was opened. Discard any unused left over food after 2 days. 3. During an observation of the kitchen/ice machine on 04/15/19 at 10:45 AM, a quart size "Ziploc" bag of food was noted under the ice in the ice machine. The bag appeared sealed and did not appear to have leaked any fluid. Simultaneously during the above observation, SM55 was queried about the bag of food. SM55 asked other employees about the food and later stated that the food in the "Ziploc" bag was fish. SM55 further stated that she had no awareness of this bag being stored in the ice and immediately removed it from the ice machine. SM55 also took further measures to ensure the ice machine would be cleaned. During a follow up observation of the kitchen/ice machine on 04/17/19 at 10:00 AM, the ice machine was noted to be out of service for cleaning and disinfection following facility procedure. A review of the facility policy on Ice Machines read the following: Purpose; To assure resident and staff safety in the use of ice machines ... Policy; The following policy should be followed to reduce the likelihood of contamination of ice	4 159	items and discarding outdated items. All staff was educated on proper ice machine utilization and sign posted. MONITOR Weekly kitchen audits will be completed by the Administrator/ Designee to ensure any out dated food items are discarded for 3 months. Daily audits for 1 month followed by weekly audits for proper utilization of the ice machine for the next 2 months. Any issues identified will be addressed and corrected. Findings from the audits will be presented to the QAPI meeting for 3 months to ensure ongoing compliance and to identify the need for further education and/or system revision. TITLE OF PERSON RESPONSIBLE FOR CORRECTION Administrator/designee will be responsible for ongoing compliance. DATE OF COMPLIANCE: Compliance will be met by 6/2/19 and on an ongoing basis.	

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4 159	Continued From page 6 storage machines ... Clean ice storage on a pre-set schedule.	4 159		
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, staff interview, and review of policy, the facility failed to maintain an infection prevention and control program to provide a sanitary environment for the following: 1. Resident (R) 25; facility failed to exchange the suction equipment/cannister and 2. Medication Cart; facility failed to remove a disposable medication cup that was stored in a container with powdery substance. Findings Include: 1) During an observation of the suction equipment in R25's room, on 04/15/2019 at 11:00 AM, the suction equipment/cannister contained approximately 100cc of white/brown liquid contents. The cannister was not marked with any date, and there was no way to tell when the content was collected and how long the suction equipment/cannister was in use. During staff interview with Certified Nurse's Aide (CNA) 73 on 04/15/2019 at 11:05 AM, CNA 73 did not know when the white/brown liquid contents	4 203	Tag 4203 Infection Control: SPECIFIC RESIDENT Resident #25 suction equipment was changed. The thickener substance was discarded. OTHER RESIDENTS Other suction machines were reviewed to ensure they are cleaned. Other thickening containers were reviewed to ensure there was not any medication cup present. Any identified issues were corrected. SYSTEMIC CHANGES Director of Nursing/designee educated nursing staff on infection control program including replacing used suction equipment and not storing medication cup in thickener container. MONITOR Weekly audits of suction equipment and thickener will be completed by Director of	6/2/19

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4 203	Continued From page 7 was collected and did not know when the suction equipment/cannister was put in use. After staff interview with Charge Nurse (CN) 59 on 04/15/2019 at 11:10 AM, CN59 acknowledged that the liquid contents in the suction equipment/cannister should have been discarded and the suction cannister should have been marked with the date that it was put in to use. CN59 subsequently removed that suction cannister and said that it will be replaced with a new one. A review of the facility policy on Resident Equipment Sanitation read the following: Policy; Regency Pacific affiliated skilled nursing facilities will prevent the spread of potentially infectious agents through contaminated equipment by using appropriate and accepted sanitation procedures. Semi-Critical Items including but not limited to: thermometers, podiatry equipment and electric razors are devices that touch mucous membranes or non-intact skin and require meticulous cleaning and disinfection between use by different residents. 2) On 04/16/19 at 03:10 PM observed a clear plastic container on the medication cart which was labeled with a date of 03/16/19. The container stored white powdery substance in it with a plastic disposable medication cup nestled in the powder. CN24 confirmed this was thickener and was not clear whether the label reflected disposal or when the thickener was provided to the nursing staff. CN24 reported there is no resident on the unit who requires thickened liquids. CN24 was asked whether the medication cup is stored in the container, CN24 acknowledged storing the medication cup in the thickener is a risk for contamination.	4 203	nursing/Designee to ensure proper cleaning and storage for 3 months. Any identified issues will be corrected. Results of the audits will be reported to the QAPI committee monthly for 3 months to ensure ongoing compliance and to identify the need for further education and/ or system revision. TITLE OF PERSON RESPONSIBLE FOR CORRECTION Director of Nursing/Designee DATE OF COMPLIANCE Compliance will be met by 6/2/19 and on an ongoing basis.	

Hawaii Dept. of Health, Office of Health Care Assurance

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