STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125030	A. BUILDING: _____ B. WING _____	06/04/2019

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4 000	Initial Comments A re-licensure survey was conducted by the Office of Health Care Assurance (OHCA) on 06/02/19 - 06/04/19. The facility was found not to be in substantial compliance with Hawaii Administrative Rules, Chapter 11-94.1 Survey Dates: 06/02/19 - 06/04/19 Survey Census: 6 Sample Size: 6 Supplemental Residents: 1	4 000		
4 101	11-94.1-22(c) Medical record system (c) The following information shall be obtained and entered in the resident's record at the time of admission to the facility: (1) Personal information such as name, date, and time of admission, date and place of birth, citizenship status, marital status, social security number, or an admission number that can be used to identify the resident without use of name when the latter is desirable; (2) Name and address of next of kin, legal guardian, surrogate, or representative holding a power of attorney; (3) Sex, height, weight, race, and identifying marks; (4) Reason for admission or referral; (5) Language spoken and understood; (6) Information relevant to religious affiliation, if any; (7) Admission diagnosis, summary of prior	4 101		6/5/19

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4 101	Continued From page 1 medical care with listing of physicians providing care, recent physical examination, tuberculosis status, and physician's orders; and (8) Advanced directives, as applicable. This Statute is not met as evidenced by: Based on record review and interviews, the facility failed to ensure for a resident who does not have an advance directive (AD), the resident was informed of his or her right to develop one, provided assistance in doing so or was periodically reassessed in his/her decision making capacity to do such for 1 of 6 residents (Resident (R) 4) selected for review. This deficient practice had the potential to affect other hospice residents on future admissions. Findings Include: Resident (R) 4 was admitted to the facility with hospice services on 03/27/19 with diagnoses including dementia with severe malnutrition and rapid weight loss. During an interview with R4 on 06/02/19, he could not answer whether he had an AD, and said to ask the staff about it. R4's record review revealed there was no documentation whether the AD information was offered and/or provided to him on admission or during his stay. On 06/03/19 at 02:25 PM, during an interview with social worker (SW) 1, she verified R4 did not have an AD. SW1 also said she had not been offering the AD information to residents who entered the facility with hospice services, but would be doing so hereon.	4 101	Kahuku Medical Center Long Term Care Resident who did not have a current Advance Directive (AD)were given written information concerning the right to accept or refuse medical or surgical treatment and, at their options, formulate an AD during the week of June 2, 2019. All Kahuku Medical Center Long Term Care Residents AD have been updated/completed as of June 5, 2019. Education on AD was provided to Social Services department and processes were updated to ensure all residents will be provided the opportunity, education and assistance in formulating, and updating, their AD. Chart audit on admission Interdisciplinary Team meeting and annual review by Director of Social Services to ensure compliance.	

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4 102	Continued From page 2	4 102		
4 102	11-94.1-22(d) Medical record system (d) Records to be maintained and updated, as necessary, for the duration of each resident's stay shall also include: (1) Appropriate authorizations and consents for medical procedures; (2) Records of all periods, with physician orders, of use of physical or chemical restraints with justification and authorization for each and documentation of ongoing assessment of resident during use of restraints; (3) Copies of initial and periodic examinations and evaluations, as well as progress notes at appropriate intervals; (4) Regular review of an overall plan of care setting forth goals to be accomplished through individually designed activities, therapies, and treatments, and indicating which professional services or individual is responsible for providing the care or service; (5) Entries describing all care, treatments, medications, tests, immunizations, and all ancillary services provided; and (6) All physician's, physician assistant's, or APRN's orders completed with appropriate documentation (signature, title, and date). This Statute is not met as evidenced by: Based on record review and interview, the facility failed to accurately document an assessment of a resident's condition upon a voluntary discharge/return to the facility, to ensure all	4 102	Education provided to nursing staff and Social Services upon findings, monthly Nursing meeting held on 6/27/2019. Staff educated on role of RN in collaboration	6/27/19

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4 102	Continued From page 3 disciplines were aware of the resident's actual experience, health status and response to continued services and treatment as a hospice resident for 1 of 6 residents (Resident (R) 56) selected for review. This deficient practice had the potential to affect any future hospice residents who may seek to discharge on his/her own accord. Findings Include: Resident (R) 56 was admitted to the facility on 05/29/19 with hospice services for congestive heart failure (CHF). Record review found that R56 was alert and oriented x 4 on admission. R56 elected to leave the facility however, on his own accord the following morning on 05/30/19 at 09:55 AM after a phone call with a family member upset him. Approximately two hours later, R56 asked to return to the facility and arrived back to resume care as a hospice resident. During an interview with R56 on 06/02/19, he said the reason he was admitted was his "CHF." R56 did not want to answer any further questions and could not be fully interviewed as to the 05/30/19 incident. On 06/03/19 at 09:49 AM, an interview with the hospice registered nurse (RN) was done. She stated R56 had been homeless prior to his admission and was estranged from his family. The hospice RN said R56 did understand the reason he was enrolled in hospice, but his mentation fluctuated due to his condition. She recalled on 05/30/19, R56 wanted to meet his family and thus left against medical advice. The hospice RN said upon his return, the hospice social worker and chaplain spoke to him on 06/01/19. The hospice RN said R56 stated he	4 102	with Hospice services. Staff educated on utilizing the interdisciplinary team when a patient is in need of intervention. Weekly chart checks of 5 random charts will be completed by Lead RN to ensure progress notes are completed Q shift and as needed to document interventions and outcomes.	

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4 102	Continued From page 4 did not want to go back being homeless and was agreeable to care in the facility. The record review however, revealed that upon R56's return to the facility on 05/30/19, there was no clinical documentation or assessments either by nursing and/or social services to show what had been done for the resident upon his return that day. On 06/04/19 at 01:08 PM, an interview with the Director of Social Services (DSS) was done. She confirmed she was informed when R56 initially left the facility against medical advice (AMA), and also when he returned a couple hours later. The DSS said it was something a family member had said to R56 which made him upset, "and he wanted to leave and although they tried to talk to him, (the RN), because she was the charge nurse that day, but he didn't want to listen." She said their plan, "from the get go was to get the hospice social workers to come in and for the nurse to educate the resident for the AMA." The DSS said the hospice social worker came to see R56 on 06/01/19, but said, "I definitely could have met him (R56) that day (05/30/19)because I was here, and I know (RN) did spend some time to talk with him." The DSS confirmed there was no follow-up note or clinical documentation on any of this. She verified "the assessment part" was missing and that otherwise it seemed the resident just returned to his room and was left alone. In addition, during the exit conference, although the Chief Nurse Executive (CNE) stated her staff RN who was involved with R56 on 05/30/19 had spent a lot of time talking to him upon his return, the CNE acknowledged it was the documentation piece that was missing.	4 102		

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4 102	Continued From page 5 As such, there was a failure to ensure R56's medical record reflected the resident's condition at the time of his return, with no assessment or documentation of the resident's actual experience upon his return, including changes to his/her physical and/or emotional state.	4 102		
4 105	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 record review and staff interview, the facility failed to accurately document the weight change for Resident (R) 3 on the Resident Assessment Instrument (RAI). Findings Include: During record review of R3, the following weights were recorded which would have indicated a weight gain: 10/07/18 - 104#, 3/17/19 - 116.6#	4 105	Education was provided to Registered Dietician on June 5th, 2019 on the formula used by CMS guidelines. MDS coordinator provided Registered Dietician with copy of Section K from MDS manual for reference when completing MDS. MDS Coordinator will perform a second check of section K within MDS to assure accurate documentation is reflected that has been completed by the Registered	6/27/19

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4 105	Continued From page 6 (weight gain compared to 10/07/18), 4/3/19 - 115.5# (weight gain compared to 10/07/18). A review of R3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/15/2019 revealed both a weight gain and a weight loss. During inquiry with Registered Nurse (RN) 4 on 06/04/19 at 08:15 AM, RN4 acknowledged that the MDS was coded wrong; weight loss was coded in error. RN4 then stated the correction will be submitted to reflect the correct weight change for R3.	4 105	Dietician with all MDS submission going forward.	
4 138	11-94.1-36(b) Admission, transfer, and discharge (b) These policies shall ensure that: (1) The facility shall not discriminate against admission of any individual as per all federal and state civil rights and anti-discrimination regulations. Should the facility not be able to provide care and services to individuals based on their age, i.e., infants and youth, or specific disability, the facility will need to indicate so in their policies and procedures and by-laws; (2) The facility shall accept only those residents whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts; (3) As changes occur in a resident's physical or mental condition necessitating a different level of service or care that cannot be adequately provided by the facility, the residents shall be transferred promptly to a facility capable	4 138		6/5/19

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4 138	Continued From page 7 of providing an appropriate level of care; (4) Except in the case of an emergency, the resident or the resident's legal guardian, family, or surrogate and the attending physician shall be informed in advance of the transfer or discharge to another facility; and (5) The facility's buildings are constructed, equipped, and maintained to protect the resident's health, and assure the safety of residents, personnel, and visitors. This Statute is not met as evidenced by: Based on observations, staff interview, and review of policy/procedure, the facility failed to secure a storage room where an electrical panel box was located. 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 Skilled Nursing Facility (SNF) Unit on 06/02/19 at 10:55 AM, a storage room, which contained an electrical panel box, was not secured. No staff members were in the immediate vicinity to prevent any residents and/or visitors from accessing the storage room/electrical panel box. Also, one resident (Resident (R) 1) was noted to be "rolling" himself around, in the wheelchair, close to where the storage room/electrical panel box was located. During a second observation of the SNF Unit, done with the Maintenance Staff (Maint Staff) 5 on 06/3/19 at 08:15 AM, the same storage room, which contained an electrical panel box, was	4 138	Key removed and closet cleared of supplies immediately upon finding. Physical lock installed on 6/5/19. Monthly rounding by facilities will be done to ensure compliance. Director of Facilities will review logs regularly for compliance.	

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4 138	Continued From page 8 again not secured. No staff members were in the immediate vicinity to prevent any residents and/or visitors from accessing the storage room/electrical panel box. Maint Staff 5 acknowledged that the storage room/electrical panel box supposed to be secured; the door should have been locked. Maint Staff 5 then stated that the matter would be taken care of. A review of facility policies and procedures was conducted with the Maintenance Manager (Maint Mgr) on 06/03/19 at 1:30 PM. Maint Mgr was not able to produce a specific facility policy when queried.	4 138		
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 a clean suction equipment/cannister for one (Resident (R) 2) of the three residents reviewed. This deficient practice put the resident at risk for the development and transmission of communicable diseases and infections. Findings Include: During an observation of the suction equipment in R2's room, on 06/02/19 at 10:44 AM, the suction	4 203	Updated Nasogastric tube removal/insertion and maintenance policy to include dating suction canisters once used, suction canisters will need to be discarded once used the following Sunday. RN's educated at monthly meeting held 06/27/2019 on the update of the policy. Patient rooms rounds will be done weekly by the charge RN on Mondays to ensure compliance.	6/27/19

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4 203	Continued From page 9 equipment/cannister contained approximately 30cc of clear/white liquid contents (appeared to be saliva). At the same time, the same liquid contents was also noted in the suction tubing. Additionally, the suction cannister was not marked with a (put in use) date, as per facility policy/process. During an observation of the same suction equipment on the next day 06/03/19 at 09:00 AM, the clear/white liquid contents previously found in the cannister and also in the suction tubing remained. The suction cannister was still not marked with any (put in use) date, as per facility policy/process. On 06/03/19 at 09:30 AM, Registered Nurse (RN) 1, was queried on the above findings. RN1 acknowledged that the suction equipment should have been emptied/cleaned accordingly and the cannister should have been marked with a (put in use) date as per facility policy/process. A review of the facility policy titled Nasogastric Tube Removal/Insertion and Maintenance stated the following: VI. Gastric Suction through NG Tube, a. Procedure - Empty canister when 75-100% full (or every 24 hours, whichever comes first), Discard of old canister lining into biohazard waste area, Replace old canister lining with fresh one...	4 203		