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 A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	125004		07/12/2019

NAME OF PROVIDER OR SUPPLIER
GARDEN ISLE HEALTHCARE AND REHABILITATION (

STREET ADDRESS, CITY, STATE, ZIP CODE
3-3420 KUHIO HIGHWAY, SUITE 300
LIHUE, HI 96766

(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 state relicensure survey was conducted from 07/09/19 through 07/12/19 by the State Agency. At the time of entrance, the resident census was 93.	4 000		
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, staff interview, and review of a list of approved abbreviations provided by the facility, the facility failed to use approved abbreviations and/or acronyms when charting in the progress notes, for four of the nine residents reviewed. With this deficient practice, there was a risk of misinterpreting the un-approved abbreviations and thus causing adverse outcomes for any, or all the residents. Findings Include:	4 105	I. Upon notification appropriate staff were in-serviced on facility approved abbreviations. Completion Date: July 25, 2019 Responsible Party: Director of Nursing and/or Designee II. A review of the last four quarters emergency room visits and hospital readmissions revealed that none were a result of use of unapproved abbreviations. Completion Date: July 24, 2019	7/28/19

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/23/19

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4 105	Continued From page 1 1. During review of the clinical notes for Resident (R) 11, the following abbreviations/ acronyms were used, in various places, in the clinical notes: "OOP, SO". According to the Accepted Abbreviations - Medical Terminology list (provided by the facility), these abbreviations/acronyms were not approved to be used for charting. 2. During review of the clinical notes for Resident (R) 27, the following abbreviations/ acronyms were used, in various places, in the clinical notes: "OOP, ATB". According to the Accepted Abbreviations - Medical Terminology list (provided by the facility), these abbreviations/acronyms were not approved to be used for charting. 3. During review of the clinical notes for Resident (R) 61, the following abbreviations/ acronyms were used, in various places, in the clinical notes: "OTA, ABT, CDI". According to the Accepted Abbreviations - Medical Terminology list (provided by the facility), these abbreviations/acronyms were not approved to be used for charting. 4. During review of the clinical notes for Resident (R) 12, the following abbreviations/ acronyms were used, in various places, in the clinical notes: "POC, ASE, ABT". According to the Accepted Abbreviations - Medical Terminology list (provided by the facility), these abbreviations/acronyms were not approved to be used for charting. On 07/11/19 at 02:24 PM, an inquiry regarding facility approved abbreviations with the Chief Nursing Officer (CNO) was made. CNO provided the list of facility approved abbreviations titled "Garden Isle Healthcare, Accepted Abbreviations - Medical Terminology" which is currently in use and being followed by the facility.	4 105	Responsible Party: Director of Nursing and/or Designee III. Facility will review and revise policy as indicated. Appropriate staff will be in-serviced on adherence to the facility approved abbreviation list. Appropriate staff will be in-serviced on the national DO NOT USE abbreviation list. Completion Date: July 25, 2019 Responsible Party: Director of Nursing and/or Designee IV. Audits will be conducted monthly for three months then quarterly thereafter to ensure compliance. The results of the audit will be presented to the Quality Assurance Performance Improvement Committee for review and follow-up as indicated. Completion Date: July 28, 2019 Responsible Party: Director of Nursing and/or Designee	

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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 record review and interviews with staff members, the facility failed to ensure a resident is provided care with respect and dignity to promote and enhance her quality of life during skin assessments resulting in the resident feeling embarrassed. Findings include: Resident (R)78 was admitted to the facility on 06/14/19 from an acute facility. R78 was discharged to the hospital on 06/25/19 and readmitted to the facility on 06/26/19. On 07/09/19 at 10:50 AM an interview was conducted with R78. R78 reported that she is uncomfortable with the skin assessment, it made her feel like a "criminal". The resident clarified, she asked to undress and lay in bed for the skin assessment. R78 further reported another staff member was also present. Queried whether the	4 115	I. Upon notification the facility process for skin assessment was reviewed and staff in-serviced on process. Completion Date: July 23, 2019 Responsible Party: Director of Nursing and/or Designee II. A review of the last four quarter in house surveys and risk investigation did not trigger above threshold through quality management software. A review of the facility complaint log did not yield any resident concerns for dignity in respect to the facility skin assessment process. Completion Date: July 20, 2019 Responsible Party: Director of Nursing and/or Designee III. The licensed nursing staff will be in-serviced on the facility skin assessment process in respect to providing dignity	7/28/19

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4 115	Continued From page 3 staff member draped her body during the assessment, R78 replied, "no". R78 also shared that she doesn't understand why another staff member has to be present and was not asked whether it was okay to have another staff member present during the assessment. R78 also stated that she doesn't understand why the skin assessment has to be done weekly. On 07/12/19 at 08:15 AM an interview was conducted with Licensed Nurse (LN)2. Inquired how are skin assessments performed. LN2 reported residents usually come from the acute hospital and are dressed in a hospital gown. LN2 reported residents are not asked to undress and are informed the nurse will check their "bottom" and for women, look under their breast. LN2 further explained the resident's hospital gown is removed only to expose areas that are being assessed. The LN confirmed there are two nurses present during the skin check to assist with turning and one person to write and one person to measure. A record review was done on 07/10/19 at 01:19 PM. A review of the admission Minimum Data Set (MDS) with assessment reference date of 06/21/19 found R78 yielded a score of 15 (cognitively intact) when the Brief Interview for Mental Status was administered. R78 was also noted to require limited assistance with one person physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture).	4 115	during completion. Dignity will be added as a standing item on department meeting agendas. Completion Date: July 24, 2019 Responsible Party: Department Managers and/or Designee IV. Audits will be conducted monthly for three months then quarterly thereafter to ensure compliance. The results of the audit will be presented to the Quality Assurance Performance Improvement Committee for review and follow-up as indicated. Completion Date: July 28, 2019 Responsible Party: Director of Nursing and/or Designee	