STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING: _____ B. WING _____	10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE HILO, HI 96720

(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 re-licensure survey conducted by the Office of Health Care Assurance was completed on October 4, 2019. The facility reported census was 91 at time of entrance.	4 000		
4 113	11-94.1-27(2) 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: (2) The right to be free of interference, coercion, discrimination, and reprisal from the facility that shall include the right to be free of chemical or physical restraints not medically indicated; This Statute is not met as evidenced by: Based on observations, staff interview, record review, review of policy, and review of Facility Reported Incident (FRI) 7641, the facility had past non-compliance; whereas, Resident (R) 2 was restrained to a wheelchair for the purpose of convenience, and not required to treat medical symptoms. Findings Include: According to the FRI 7641 (received from the facility) and record review, a staff member found R2 restrained to a wheelchair on 05/12/19 at 07:48 AM. R2 was sitting up, alert and smiling at	4 113	SEE F604 -- Corrected Past Non-Compliance Resident Specific Intervention: R2's care plan for positioning while in wheelchair was re-evaluated and proper interventions for positioning were placed. Care plan was updated with current appropriate and safe interventions. No restraint is currently noted for resident. See completed FRI 7641.	11/6/19

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4 113	Continued From page 1 that time. There was no harm to R2. Immediately after the staff was made aware of that restraint, it was removed and reported appropriately. A review of R2's medical record showed the following diagnosis: dementia, chronic atrial fibrillation, post-traumatic stress disorder (PTSD), major depressive disorder, cerebral vascular accident (CVA), personality/behavioral disorder. On 09/30/19 at 10:00 AM, during survey, R2 was observed sitting up in a wheelchair using an upper body harness to support being upright. R2 was alert and appeared in no acute distress. R2's speech was not clear (baseline) and was not able to answer questions about the FRI 7641. R2 needed assistance with mobility and had a doctor's order which read; upper body harness while up in wheelchair during meals and activities to support upright positioning. A review of R2's care plan showed the following relative interventions: 1. For the upper body harness for positioning, 2. mobility, 3. falls, and 4. skin integrity. On 10/02/19 at 02:30 PM, the Regional Nurse Consultant (RNC) provided the full investigation notes for the FRI 7641. The notes showed evidence that the investigation was thorough. Evidence included interviewing other residents, obtaining written statements from employees, providing education/training/in-service on the prohibition of abuse and restraints, reviewing facility policy on Freedom from Abuse, Neglect, and Exploitation. A Performance Improvement Action Plan/Audit was also initiated and on-going to monitor for compliance.	4 113	Facility Wide Intervention: All residents who require assistance with positioning in a wheelchair and who are dependent upon staff support are at risk for the improper use of restraints. Care plans were updated per Policy and procedure for restraint utilization was reviewed and reconfirmed. See completed FRI 7641. Education: Nursing staff were educated on the policy and procedure on the prohibition of abuse and restraints. Initiated 5/12/19 per completed FRI 7641. Quality Assurance / Performance Improvement: Facility completed audit for residents who require assistance with positioning in wheelchair and who are dependent upon staff support were evaluated and findings brought to QAPI per completed FRI 7641. Responsible Member: DON or Designee	

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4 113	Continued From page 2 On 10/03/19 at 09:45 AM, Registered Nurse (RN) 75 was interviewed and asked about knowledge of FRI 7641 education/training/in-service. RN75 was able to recall FRI 7641 education/training/in-service on the prohibition of abuse and restraints. RN75 was also able to talk about the on-going monitoring for compliance.	4 113		