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CLARENCE TC CHING VILLAS AT ST FRANCIS	2230 LILIHA STREET HON, HI 96817

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4 000	Initial Comments A re-licensure survey was conducted by the Office of Health Care Assurance (OHCA) from 01/22/20 through 01/27/20. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. The census was 101 residents with an initial sample of 40. Six facility reported incidents (FRI) were investigated during the survey, Aspen Complaints/Incidents Tracking System (ACTS) #7813, #7258, #7995, #7264, #7687 and #8015. ACTS #7813, 7687 and #8015 were unsubstantiated. ACTS #7258, #7995, #7264 were substantiated in which the facility was found to not be in substantial compliance with 42 CFR 483 Subpart 1.	4 000		
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	4 149		3/12/20

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4 149	Continued From page 1 (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 observations, staff interview, and record review, the facility failed to ensure care plan interventions to maintain a safe environment for Resident (R)16 was implemented as evidenced by chairs obstructing the walkway in R16's room. As a result of this deficiency, R16 is at an increased risk of falls and injury. A second resident, R248's care plan did not include information pertinent to the resident's diagnosis and health status. R248 was diagnosed with esophageal varices with active bleeding. The care plan did not include goals, objectives and measurable outcomes to address the resident's risk for bleeding related to the diagnosis of esophageal varices with active bleeding. The deficient practice places R248 at an increased risk of injury. Findings include: 1) Cross-Reference to F689 Record review documented R16 was admitted on 12/05/19 with diagnoses including history of falls, weakness, right left leg pain, anemia, peripheral vascular disease, cardiac pacemaker, old myocardial infraction, and disorder of bone density and structure. R16's fall risk assessment documented a high risk of falls (score=18). Review of the care plan documented R16 has a history of falls at home prior to admission within the last month. Interventions include, "keep areas free of obstruction to reduce the risk of falls	4 149	Submission and implementation of this plan of correction shall not constitute an admission by the Clarence TC Ching Villas at St Francis to any allegations of deficiency as contained in the Summary Statement of Deficiencies or agreement with claims made therein, rather, this plan is submitted in accordance with State and Federal requirements. 1. R16□'s care plan was reviewed and updated as of 3/2/20. R248 is no longer in the facility. 2. Residents assessed as a high risk of falls, were identified and care plans were reviewed and revised as indicated. Care plans of residents with an active diagnosis of esophageal varices with active bleeding and/or GI bleed were reviewed to ensure care plan interventions were in place for bleeding precautions. 3. MDS staff were re-educated on utilizing the RAI manual for developing a Comprehensive Care Plan. 4. Director of Nursing or qualified designee will conduct weekly care plan audits of residents with a diagnosis of esophageal varices with active bleeding and/or GI hemorrhage to ensure bleeding precautions are in place monthly x3 months or until substantial compliance has been achieved. Results of the audits will be presented to the Quality Assurance	

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4 149	Continued From page 2 or injury." On 01/22/20 at 09:30 AM, observed R16 sitting at the edge of the bed facing the window. R16 reported that he/she does walk to the restroom at times without assistance. There was a single chair placed with the back of the chair up against the wall under the window. When asked about the placement of the chair, the resident stated that it was hard to get around the chair, but he/she will try to. On 01/27/20 at 10:00 AM, observed R16 resting in bed. There were 2 chairs on the left side of the bed near the foot of the bed, against the wall. A large wedge to reposition R16 was placed on top of and hung off the side of the chair. The minimal space and the placement of the chairs decreased R16's walkway to approximately 1.5 feet. Certified nursing assistant (CNA)8 confirmed R16 does not always call staff for help and has been found ambulating by himself/herself. At approximately 11:52 AM, observed the room set-up with Nurse Manager (NM)4. NM4 confirmed the placement of the chairs and large positioning wedge was a fall risk hazard and obstructed R16's walkway to create an unsafe environment. 2) R248 is an 85-year-old female admitted on 01/10/20 with a diagnosis of acute kidney failure, acute hemorrhagic anemia, esophageal varices with bleeding, gastrointestinal (GI) hemorrhage, ascites, type two diabetes mellitus, and cirrhosis of the liver. During an interview with R248 on 01/22/20 at 01:42 PM stated that she came in due to bleeding from the varices, and that she has cirrhosis.	4 149	Performance Improvement Committee for review and follow-up as indicated.	

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4 149	Continued From page 3 Electronic medical record (EMR) reviewed. R248 diagnosed with esophageal varices with bleeding and acute post hemorrhagic anemia 01/10/20, portal hypertension, acute kidney failure, cirrhosis of liver, GI bleed and hematemesis (blood in the vomit). R248 care plan dated 01/13/20 reviewed. Current problems include chronic urinary tract infection, personal preferences, short term memory problem, nutrition risk related to overweight, and risk for dehydration. No interventions included bleeding precautions related to esophageal varices and history of GI bleeding. During an interview with Registered Nurse (RN)25 on 01/27/20 at 11:29 AM stated that the care plan is created when the guest gets admitted. It is based on the diagnosis and the reason why they came in. The Interdisciplinary team (IDT) update it with problems that the resident wishes to do. Care Planning policy reviewed, Med pass inc, 01/01/2010. Purpose. The plan of care will be developed based on the Social Service (SS) assessment and history and will guide the SS and IDT staff in helping the resident to achieve and maintain his/ her maximum potential. The care plan should be developed no later than seven (7) days following the completion of the comprehensive assessment. During an interview with the minimum data set (MDS) coordinator on 01/27/20 at 01:17 PM, stated, her care plan is not being done, the nurses should be monitoring it and charting on it. I've got the nurses notes, and R248 was admitted for acute anemia related to esophageal varices	4 149		

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4 149	Continued From page 4 with bleeding. The nursing staff should be monitoring her and charting on it.	4 149		
4 152	11-94.1-39(e) Nursing services (e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures. The policies and procedures shall include but not be limited to: (1) Written procedures for personnel to follow in an emergency including: (A) Care of the resident; (B) Notification of the attending physician and other persons responsible for the resident; and (C) Arrangements for transportation, hospitalization, or other appropriate services; (2) All treatment and care provided relative to the resident's needs and requirements for documentation; and (3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized This Statute is not met as evidenced by: Based on observation, record review, interview with resident and staff members, and a review of the facility's policy and procedures, the facility	4 152	1. Registered Nurse leaving medications at bedside was identified and education provided by Director of Nursing regarding	3/12/20

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4 152	Continued From page 5 failed to ensure the right to self-administer medications were exercised only when the interdisciplinary team determined this practice is clinically appropriate for one resident (Resident 397) in the active sample. Findings include: Cross Reference to F755 and F842. Resident (R)397 was observed with medications left for him/her to self-administer on the bedside tray. Record review and interview with staff members found there is no documentation that R397 was assessed by an interdisciplinary team to determine he/she has the ability to exercise his/her right to self-administer medications safely and it is clinically appropriate. Also, the facility did not follow their policy and procedures for self-administration of medications by a resident.	4 152	clinically appropriate practice. R397 is no longer in the facility. 2. An audit of resident rooms was completed on 3/11/20, to ensure no medications were at bedside. Appropriate follow up was conducted as indicated. 3. Interdisciplinary Team and licensed staff have been in-serviced on Residents□ Rights to self-administer medications and process for residents who request to self-administer medications. 4. Director of Nursing or qualified designee will conduct audits weekly for 4 weeks and monthly x3 months or until substantial compliance has been achieved. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and follow-up as indicated.	
4 185	11-94.1-46(b) Pharmaceutical services (b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and director of nursing that: (1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs;	4 185		3/12/20

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4 185	Continued From page 6 (2) Is reviewed at least every two years and revised as necessary to keep abreast of current developments in overall drug usage; and (3) Has a drug recall procedure that can be readily implemented. This Statute is not met as evidenced by: Based on observation, record review, interview with staff and resident, and a review of the facility's policy and procedures, the facility failed to ensure administration of medications were administered under the supervision of a nurse. The facility also failed to ensure a record for controlled drugs are maintained. Findings include: 1) Cross Reference F554 and F842. On 01/22/20 at 08:10 AM during a screening of residents, Resident (R)397 was awake and seated on the side of the bed. R397's bedside tray was observed with a small plastic cup with seven pills in it and a small cup of water. R397 was asked about the pills in the cup. R397 reported the medications are left as he/she does not like taking medications and it is taken when he/she is ready. On 01/22/20 at 10:25 AM a resident interview was conducted with R397. R397 answered questions appropriately; however, later appeared irritable and the interview was discontinued. R397 was focused on familial issues with his/her children. On 01/23/20 at 10:52 AM and 01/24/20 at 08:16 AM a record review was done for R397. R397	4 185	1. Charge nurse was re-educated by the Director of Nursing. R397 had not requested to self-administer medications; therefore, an IDT review was not done. Nurses who missed signing the narcotic log were provided individual education on the importance of ensuring the narcotic log is signed off at the beginning and ending of each shift. 2. Unit manager performed an audit on narcotic logs on 1/27/20. No other issues found. 3. Licensed nurses were in-serviced on the reconciliation of narcotics process on 2/12/20. 4. Director of Nursing or qualified designee will conduct weekly audits of the narcotic log reconciliation for one month then weekly for 3 months or until substantial compliance is achieved. Results of audits will be documented and presented to the Quality Assurance Performance Improvement Committee, for outcomes review and follow up as indicated.	

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4 185	Continued From page 7 was admitted to the facility on 01/17/20. The admission diagnoses include cardiac arrest; secondary elevated troponin, refusal of blood transfusion due to religious belief; ventricular tachycardia; hyperkalemia; diabetes mellitus; and end stage renal disease (receives in-center hemodialysis). A review of the physician orders found the following scheduled medications for 08:00 AM: Renal tab (one tab); amiodarone 400 mg (400 mg for paroxysmal atrial fibrillation); Eliquis 2.5 tablet (2.5 mg for paroxysmal atrial fibrillation); calcium acetate 667 mg (three capsules for end stage renal disease); metoprolol succinate ER 50 mg (two times daily for blood pressure); gabapentin 100 mg (three times a week for pain); and Renvela 800 mg (three times daily for end stage renal disease). There was no physician order for self-administration of medications. Further review found no documentation R397 was assessed for abilities to self-administer medications. Also, there was no documentation of a baseline plan of care to address the interventions for self-administration of medications. On 01/23/20 at 10:00 AM an interview was conducted with Registered Nurse (RN)5. RN5 confirmed he/she is the nurse that administers R397's medication. RN5 reported the medications are left with the resident as he/she is alert and does not like the staff to watch him/her take the medications (resident gets upset when the RN stands there while he/she takes the medication). The RN has instructed the resident to call when he/she completes taking all the medication. Inquired how the RN ensures the resident took all the medication, the RN replied	4 185		

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4 185	Continued From page 8	4 185		

he/she will check on the resident "once in a while". The RN also reported R397 sometimes gets upset when you return to check. Further queried how long do you wait before going back. RN5 responded, he/she moves to the next resident and closely monitors R397. The RN was asked how the facility determines whether a resident can self-administer his/her own medications, who makes the determination. RN5 replied residents that are alert x4 can administer their own medication; however, still requires supervision and needs to be checked. Lastly asked the RN how nurses are notified of which residents have been identified as competent to self-administer medications. The RN responded sometimes there is a paper assessment.

On 01/24/20 at 10:10 AM an interview and concurrent record review was conducted with Nurse Manager (NM)5. The observation of the morning of 01/22/20 of R397 with the medication cup filled with seven pills left on the bedside try was shared with NM5. Inquired whether R397 was assessed for self-administration of medication. The NM responded the resident was not assessed; however, it may be possible that the nurses did the assessment. A request was made to review the assessment, the NM was unable to find an assessment in the electronic health record. A review of the physician's order and the Medication Administration Record (MAR) was done with the NM. The NM confirmed R397 was prescribed seven medications for 08:00 AM and a review of the MAR found documentation the seven prescribed medications were administered as evidenced by the initials of the administering nurse (LN5). NM5 confirmed the nurses are supposed to watch the guest (resident take the medication). On 01/24/20 at 10:52 AM the NM provided copies of the physician's orders

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4 185	Continued From page 9 and MAR. On 01/21/20 at 10:00 AM, the facility provided a copy of the policy and procedure for "Medication Administration, Self-Administration by Resident". The policy notes the following: "Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe, and the medications are appropriate and safe for self-administration." The procedures include an assessment by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process. Also, a skill assessment is conducted to determine the resident's abilities. The results of the assessment are recorded in the Medication Self-Administration Assessment which is placed in the resident's medical record. 2) On 01/23/20 at 09:59 AM a review of the medication cart with RN5 found the reconciliation of controlled medications were accurate. The RN provided a folder containing "Narcotic Count Sign in Sheet" from 01/01/20 to 01/23/20. The sign in sheet requires two staff initials daily for every shift (in-coming and out-going) with three shifts per day. The following entries were missing a second initial to attest the accuracy of the narcotic count: 01/03/20 at 1430, off-going staff; 01/05/20 at 0630, on-coming staff; 01/05/20 at 1430, off-going staff; 01/19/20 at 1430, on-gong staff; 01/19/20 at 2230, off-going staff; and 01/21/20 at 2230, off-going staff. RN5 confirmed the missing signatures.	4 185		
4 203	11-94.1-53(a) Infection control	4 203		3/12/20

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4 203	Continued From page 10 (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 observations and staff interviews, the facility failed to ensure a reusable shared patient care equipment, blood pressure cuff, was properly disinfected before and after use for Resident (R)449 to prevent the possible spread of infection. As a result of this deficient practice, residents on the third floor could potentially be at an increased risk of acquiring an infection from reusable shared patient care equipment. Findings include: On 01/23/20 at 08:58 AM, observed registered Nurse (RN)4 apply the blood pressure (BP) cuff to Resident (R)449's arm. RN4 was observed not to disinfect the BP cuff prior to removing it from R449's room. After exiting the room, RN4 immediately plugged the BP machine in the hallway, walked away, and proceeded onto the next task without disinfecting the BP cuff. Inquired with RN4 regarding disinfecting the BP cuff. RN4 confirmed the BP cuff is used for multiple residents and he/she "forgot" to disinfect the BP machine/cuff prior to using the equipment for R449 and before leaving the BP machine in the hallway for use on another resident. On 01/27/20 at 10:20 AM, inquired with Infection Control Preventionist (ICP)1 and Nurse Manager (NM)6 regarding the observation made on	4 203	1. Re-education on disinfecting blood pressure cuff with Sani wipes (purple top) between residents. 2. Facility audits was completed to ensure proper equipment utilization. Appropriate follow up was conducted as indicated. 3. Licensed nurses and CNAs were educated on the importance of disinfecting shared equipment between residents in accordance with the infection control policy and procedure. 4. Director of Nursing or qualified designee will complete audits on all floors/shifts to ensure staff are adhering to infection control policy weekly x4, then monthly x3 or until substantial compliance is achieved. Results of audits will be documented and presented to the Quality Assurance Performance Improvement Committee, for outcomes review and follow up as indicated.	

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4 203	Continued From page 11 01/23/20 at 08:58 AM. ICP1 and NM6 both confirmed the BP machine and cuff should have been disinfected with the Super Sani Cloth-Germicidal (purple top) wipes prior to removing the BP machine and cuff from R449's room to prevent the possible spread of infection.	4 203		