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KAUAI VETERANS MEMORIAL HOSPITAL	4643 WAIMEA CANYON DRIVE WAIMEA, HI 96796

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4 000	Initial Comments A relicensing survey was conducted by the Office of Healthcare Assurance (OHCA). The facility was found not to be in substantial compliance with Hawaii Administrative Rules, Title 11, Chapter 94.1 Nursing facilities. Survey dates: 03/02/21 to 03/05/21 Survey Census: 20 Sample size: 17	4 000		
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 observation, interview and record review, the facility failed to treat eight out of seventeen residents with respect and dignity in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility failed to protect and promote the rights of R1, R5, R9, R10, R15, R17, R120.	4 115		

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

Electronically Signed

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4 115	Continued From page 1 Findings include: 1) On 03/03/21 at 09:05 AM, a modified resident council (RC) meeting was held with Resident (R1, R17, R5, R120 and R10). A resident attending RC stated "They think we are kids and we have dementia. We play these stupid games like a child. I feel like we are kids. We want adult things. I want adult coloring. They have coloring books that have kids and animals in it. They have coloring books that are for kids. We don't have search words." On 03/03/21 at 11:30 AM, surveyor interviewed activities director (AD) and activities coordinator (AC). Surveyor asked regarding coloring books, crayons, coloring pencils for the choices for residents. Various new coloring books for the residents were kept in a file and stored. Most of the books were labeled for age 3 years and up, however, there were a few word search and adult books. AC stated that the books were assigned to the residents and they were not shown what was available to choose from. AC showed this surveyor the coloring basket which included sharpies, coloring markers, coloring pencils. The supplies were shown to R1, R5 and R15 in the dining area. They stated, "We weren't shown these before. We were not offered the coloring pencils, or coloring pens to use, only crayons." AC and AD were standing with the surveyor concurrently interviewing residents and did not comment. AD stated, "I'm not usually here." AD stated, "I am between two facilities." 2) On 03/03/21 at 09:05 AM, a modified resident council (RC) meeting was held with Resident (R1, R17, R5, R120 and R10). A resident attending RC stated "Our snacks are the same every day	4 115		

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4 115	Continued From page 2	4 115		

and three times a day. We get offered tuna sandwich, tea, prune juice, cranberry juice. We want a variety of choice and options."

On 03/04/21 at 09:32 AM, an interview was done with the Director of Nursing (DON). Information regarding the resident's requests for a variety of options for snacks was discussed. DON agreed about the snacks being the same and the resident's not having choices. DON stated "I agree with the snack requests, I strongly agree.

3) Observation on 03/03/21 at 12:00 PM was done in the main dining area. Barbecued chicken was the main protein served. R120 had been served a piece of chicken that needed to be cut. It was noted that R120 appeared to have deformities of her hands and her finger joints were large and bent. R120 attempted to cut her chicken with a regular fork which did not fit her hand and kept twirling in her hand. R120 also had to use a butterknife to cut the chicken which was difficult for the resident to cut through.

On 03/03/21 at 1:41 PM, an interview was done with the occupational therapy manager who concurrently observed R120 and stated that the resident could benefit from built up utensils and would investigate the matter.

An observation on 03/03/21 at 12:08 PM was made of R15 during dining. R15 stated she was upset because she received a butter knife instead of a knife that could cut through the chicken. When she asked for another knife, they brought her another butter knife. (refer F810)

4) During the lunch observation in the dining/activity room on the long term care unit on 03/03/21 at 11:58 AM, surveyor noted R9 sitting

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4 115	Continued From page 3	4 115		

in a wheelchair at a table with another resident who was independently eating lunch. R9 had a full plate of food sitting on the table in front of her. The plate consisted of chopped roasted chicken, white rice and cut up bread pudding. With her right hand, she slowly raised the spoon with a small piece of the bread pudding up to her mouth, opened her lips to take a bite and the food dropped on the apron she was wearing. R9 made 5 more attempts to take a bite of the food and spilled it on the apron. At 12:21 PM, 23 minutes since R9 received her food, a certified nurses' aide (CNA) sat down next to R9 to assist her with her meal. CNA fed R9 the rest of her food.

5) On 03/03/21 at 3:20 PM after interviewing R1 in her room, surveyor went to the activities room to let staff know that R1 was alone. Surveyor observed that several of the unit staff were eating bagels and talking amongst themselves while several residents were doing activities.

A record review of the facility's Resident's Rights (1992) on 03/05/21 at 11:21 AM revealed "Quality of Life - The facility must care for you in a manner that enhances your quality of life" and "Dignity - The facility will treat you with dignity and respect in full recognition of your individuality."

In an interview with the DON on 03/05/21 at 12:08 PM, she was asked as to the location of where the facility's staff eat their meals and snacks and she stated outside on the patio or in the staff dining room.

6) An interview was done with R1 on 03/03/21 at 1:49 PM in her room. R1 was sitting up in her wheelchair watching a television program with the volume up, waiting for her physical therapy (PT) appointment. R1 turned down the volume of the

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4 115	Continued From page 4 television after surveyor asked her if she could be interviewed. She was found to be alert and oriented to self, time, place, and situation. She stated that she is unable to make her own choices in the facility. She is unable to turn up her volume on her television to watch her television programs because staff tell her that she is unable to make it loud. She stated that she has had difficulty hearing out of her left ear but does not wear a hearing aid. She had wanted to close the door to her room to minimize the television noise but was told by staff that she would be unable to do so. She stated that she had talked to the DON about her need for a Bluetooth or headphone to hear her television programs, but her issue had not been resolved. A review of R1's EHR was done on 03/04/21 at 09:20 AM. R1 is a 75-year-old female with right sided weakness due to her cerebral palsy affecting the use of her right arm and leg and is receiving physical therapy services for strengthening. Review of her Minimum Data Set (MDS) assessment of 01/26/21 revealed that her ability to hear is with "minimal difficulty - difficulty in some environments (eg. when person speaks softly or setting is noisy)." R1's "LTC (long term care) Psychosocial Well-Being IPOC (individualized plan of care) last updated on 02/04/21 was reviewed. It stated, "I feel that my personal choices are important and given in consideration (GOAL)." An observation made of R1 on 03/05/21 at 09:22 AM found R1 watching television in her room with the volume increased. R1 stated that she was still unable to hear her television program. She also stated that she asked the DON again for Bluetooth or headphones.	4 115		

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4 115	Continued From page 5 An interview was conducted with the DON on 03/05/21 at 12:08 PM in her office. Surveyor inquired about R1's inability to hear her television programs, her need for an assistive device and about the inability to close her room door. The DON stated that due to R1's roommate's fall risk and to maintain her roommate's safety, the door to R1's room cannot be closed according to the facility's policy. She also stated that they do not have a Bluetooth device available as an assistive device for the television audio, but they do have an amplifier. She then stated that she would have R1 fitted for the amplifier.	4 115		
4 118	11-94.1-27(7) 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: (7) The right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive; □ This Statute is not met as evidenced by: Based on record review and interview the facility failed to provide information on formulating an Advance Healthcare Directive (AHCD) for one Resident (R)3. The deficient practice affects resident's rights to make their healthcare decisions known when they are no longer able	4 118		

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4 118	Continued From page 6 based on their cognitive ability. Finding includes: Surveyor reviewed the electronic medical record (EMR) and paper chart for R3 on 03/04/21 at 2:35 PM. There was no Advance Healthcare Directives (AHCD) or documentation found to indicate the resident/representative was offered information on how to formulate an AHCD. Surveyor received and reviewed the declaration of Authority to Act as Surrogate provided by the Regional quality director on 03/05/21 at 08:29 AM. The declaration did not contain an AHCD for R3. Surveyor interviewed the social worker (SW) on 03/05/21 at 11:30 AM and asked her to explain the process for obtaining and/ or providing information on AHCD to residents or their representatives. The SW explained that when a resident is admitted to the facility, we ask the resident or the family member if there is a power of attorney (POA) or AHCD at the time of admission. If they do not have one, then the resident has to be the one who is signing the ADHC or the Family member acts as the surrogate. If they don't have an AHCD then we do the POLST (provider orders for life-sustaining treatment) and the surrogate signs it. Surveyor noted that R3 did not have an AHCD, or documentation in the record that information was offered to R3's representative.	4 118		
4 125	11-94.1-27(14) Resident rights and facility practices	4 125		

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4 125	Continued From page 7 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: (14) The right to personal privacy and confidentiality of personal and clinical records; This Statute is not met as evidenced by: Based on observation, interviews and record review, the facility could have potentially not provided privacy for R15's virtual visit with family. The facility did fail to provide privacy for R1 and R17 during visits with their friends or family. The deficient practice made R1 feel like "she was being watched" and R17 not want to sign up for visitations with her family. Findings include: 1) An observation of R15 was made on 03/03/21 at 2:36 PM in the activities room with several other residents and staff. The recreation aide (RA)1 loudly asked R15 who she wanted to have a virtual visit with and asked if it was with her son and daughter-in-law. She placed the iPad, attached to a rolling contraption, in front of R15. A staff member, standing behind the surveyor, was overhead telling RA1 that privacy needed to be provided to R15 for her virtual visit. RA1 then assisted R15 out of the activities room with the mobile iPad equipment. A record review of R15's electronic health record (EHR) was done on 03/04/21 at 09:20 AM. Her annual Minimum Data Set (MDS) assessment	4 125		

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4 125	Continued From page 8 dated 01/14/21 revealed that R15 did not wear hearing aids. 2) An interview was done with R1 on 03/03/21 at 2:56 PM in her room. She stated that during a recent visit with her friend she felt like "she was being watched" and felt like she could be heard by staff. During the interview, surveyor closed the door to R1's room because staff were in the hallway just outside of the doorway. A review of R1's medical record was done on 03/04/21 at 09:45 AM. Her initial MDS assessment of 01/26/21 revealed that R1 did not have any mental disorder that detaches her from reality. 3) An interview was conducted with R17 on 03/04/21 at 09:09 AM in her room. She was found to be alert and oriented to self, place, time and situation. She stated that she does not sign up for visits with her family because the facility does not provide privacy. She further stated that the location where visits are conducted is outside where "you can hear everything." A review of R17's medical record on 03/04/21 at 10:00 AM was done. She is a 93-year-old retired registered nurse (RN) with heart disease. Her quarterly MDS assessment of 01/29/21, showed that she was cognitively intact with a BIMS score of 15 and does not suffer from any mental disorder detaching her from reality. An interview was conducted with the Activities Director (AD) on 03/05/21 at 11:33 AM. She stated that resident virtual visits are done in the hallway, outdoor patio or activities room supervised by staff. They are planning to provide more privacy for residents to do virtual visits by converting their isolation room into a visitation	4 125		

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4 125	Continued From page 9 area. They have three iPads which will be segregated into stations and the computer will be set up by their information technologist (IT) with a camera. There will be a total of four separate stations where virtual visits for residents will occur.	4 125		
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on observation, interview and policy review, the facility failed to provide sufficient nurse staffing with a second licensed nurse. The deficient practice affects the safety and quality of care for the residents. The residents on the unit are also not receiving any restorative care which has resulted in decline in their activity of daily living (ADL)s. Finding includes: 1) During an observation on 03/03/21 at 1:22 PM, surveyor observed one Registered Nurse (RN) on the unit providing care to residents. Direct Nurse staffing chart posted on the unit stated two RNs on duty for day shift. Surveyor reviewed the Kauai Veterans Memorial Hospital (KVMH) Long Term Care (LTC) facility	4 148		

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4 148	Continued From page 10 assessment on 03/03/21 at 1:00 PM. On page 7, "3.2 Staffing Plan - LTC 1 (one) RN, 1 (one) Licensed Practice Nurse (LPN) and 3-4 (three to four) certified nurse aides (CNA)'s average needed per 8-hour shift/ 7 days weekly. Days is 0700-1500. Other positions/ indirect care LTC Nurse Manager/ RAI Coordinator is needed 0700-1500: Monday - Friday, 1 (one) RN. " During the lunch meal on 03/03/21 at 12:00 PM surveyor observed one RN providing the medications to the residents in the hallway away from the activity room. The CNAs were assisting residents with the lunch meal. Activity staff were noted to be on the unit to pass trays, then left the unit to take their lunch break. No RN was present working in the dining room during the lunch meal. The Nurse Manager/Director of Nursing (DON) came out to the unit for a brief visit then returned to her office outside the unit. One resident was observed waiting to be assisted with her lunch meal. (Cross reference F677). Surveyor observed the DON in her office next to nurse's station on 03/03/21 at 2:59 PM, the staff RN was sitting at nurse's station, outside the closed doors of the unit, charting, On 03/04/21 at 09:01 AM surveyor noted a second RN working on the unit passing medications. Surveyor spoke with the DON on 03/04/21 at 09:07 AM when asked about the 2nd RN, she stated, "Sometimes I have a surplus of nurses, when they aren't on vacation, I can staff two RN's, today we have 4 CNA's which is nice. I'm hiring an additional CNA for the night shift. Since the pandemic started, our residents are more restless."	4 148		

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4 148	Continued From page 11 Surveyor interviewed the DON on 03/05/21 at 12:28 PM. When asked about the staffing requirement of 2 RN's (per the facility assessment) she stated that she is at the facility Monday to Friday and has at least one RN on duty all the time. "I make myself available as the second RN." When asked about the restorative care, she stated, "We are hiring a restorative aide to provide restorative services. If the residents are on PT, they get restorative services."	4 148		
4 153	11-94.1-40(a) Dietary services (a) The food and nutritional needs of the residents shall be met through a nourishing, well-balanced diet in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, and shall be adjusted for age, sex, activity, and disability. (1) At least three meals shall be served daily at regular times with not more than a fourteen hour span between a substantial evening meal and breakfast on the following day; (2) Between meals nourishment that is consistent with the resident's needs shall be offered routinely and shall include a regular schedule of hydration to meet each resident's needs; (3) Appropriate substitution of foods shall be promptly offered to all residents as necessary; (4) Food shall be served in a form consistent with the needs of the resident and the resident's ability to consume it;	4 153		

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4 153	Continued From page 12 (5) Food shall be served with appropriate utensils; (6) Residents needing special equipment, implements, or utensils to assist them when eating shall have the items provided by the facility; and (7) There shall be a sufficient number of competent personnel to fulfill the food and nutrition needs of residents. Paid feeding attendants shall be trained as per the facility's state-approved training protocol. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to provide one resident (R)9 with assistance to eat her lunch meal. She experienced weight loss of 8 pounds over the past 3 months. The facility also failed to provide the right equipment or utensil to R120 and R15 for them to enjoy their meal. These deficient practices interferes with the quality of life for R9, R15 and R120. Findings include: 1) During the lunch observation in the dining/activity room on the long term care unit on 03/03/21 at 11:58 AM surveyor noted R9 sitting in a wheelchair at a table with another resident who was independently eating lunch. R9 had a full plate of food sitting on the table in front of her. The plate consisted of chopped roasted chicken, white rice and cut up bread pudding. With her right hand she slowly raised the spoon with a small piece of the bread pudding up to her mouth, opened her lips to take a bite and dropped the	4 153		

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KAUAI VETERANS MEMORIAL HOSPITAL	4643 WAIMEA CANYON DRIVE WAIMEA, HI 96796

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4 153	Continued From page 13	4 153		

food on the apron she was wearing. R9 made 5 more attempts to take a bite of the food and spilled it on the apron. At 12:21 PM, 23 minutes since R9 received her food, a certified nurses' aide (CNA) sat down next to R9 to assist her to eat her meal. CNA fed R9 the rest of her food. (Cross reference to F725 sufficient Nurse staffing).

Surveyor reviewed the minimum data set (MDS) quarterly review dated 11/15/20. Eating: Scored 3 for extensive assist.

Surveyor interviewed the Registered Dietitian (RD) on 03/05/21 at 11:47 AM. Surveyor asked the RD to explain the process to evaluate a resident who is having difficulty eating. Surveyor mentioned that R9 was noted to have a difficult time trying to eat lunch. The RD explained that either nursing staff will notify her of a resident with difficulty eating or we can discuss it at the quarterly inter disciplinary team meeting. RD stated the assessment was done on 02/20/21. Will provide a copy of the functional status evaluation and nutrition evaluation from that date.

Surveyor reviewed the Nutrition evaluation dated 02/18/21 for R9. Nutrition analysis Summary: "Weight dated 02/04/21 105.3 pounds. Stable past 5 month, down 8 pounds past 3 months. Noted resident with weight loss past 3 months, possibly r/t (related to) advanced age and variable intakes. Resident with baseline fair intakes at 41% average and insufficient fluids."

2) Observation on 03/03/21 at 12:00 PM was done in the main dining area. Barbecued chicken was the main protein served. R120 had been served a piece of chicken that needed to be cut. It was noted that R120 appeared to have

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4 153	Continued From page 14 deformities of her hands and finger joints were large and bent. R120 attempted to cut her chicken with a regular fork which did not fit her hand and kept twirling in her hand. R120 also had to use a butterknife to cut the chicken which was difficult for the resident to cut through the chicken. On 03/03/21 at 1:41 PM, an interview with Occupational therapy manager observed R120 and stated that the resident could benefit from built up utensils and would investigate the matter. 3) Observation on 03/03/21 at 12:08 PM of R15 during dining. R15 stated she was upset because she received a butter knife instead of a knife that could not cut through the chicken. When she asked for another knife, they brought her another butter knife.	4 153		
4 160	11-94.1-41(b) Storage and handling of food (b) Effective procedures to promptly and consistently clean all equipment and work areas shall be enforced. This Statute is not met as evidenced by: Based on observation, interview and policy review, the facility failed to maintain a clean, sanitary kitchen. The deficient practice places residents, staff and visitors at an increased risk of illness. Finding includes: Surveyor conducted an observation of the kitchen on 03/05/21 at 10:29 AM and noted the three ceiling fans in the kitchen/ cook area with black	4 160		

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4 160	Continued From page 15 dust. Noted the fluorescent light cover over the cook sink/ stove area with gray dust. Surveyor pointed out the dusty fans and light and asked the kitchen manager (KM) how often the fans and lights are cleaned. KM stated about once per month. Surveyor requested the kitchen cleaning policy on 03/05/21 at 12:56 PM. Surveyor reviewed the Nutritional services policy and procedure dated February 23, 2021 on 03/05/21 at 1:30 PM, "The kitchen manager will list daily/weekly cleaning jobs that are needed to be done to maintain a clean and orderly kitchen. The employee is responsible for completing the job and signs off on the list once the job is completed. The list will be completed on a daily/weekly basis by the kitchen manager."	4 160		
4 177	11-94.1-44(a) Specialized rehabiiltation services (a) The facility shall provide for specialized and supportive rehabilitation services, including occupational therapy, physical therapy, and speech therapy, according to the needs of each resident, either directly by qualified staff or through arrangements with qualified outside resources. Services shall be programmed to: (1) Preserve and improve the resident's maximal abilities for independent function; (2) Prevent, insofar as possible, irreversible or progressive disabilities; and (3) Provide for the procurement and maintenance of assistive devices as needed by the resident to adapt and function within the	4 177		

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4 177	Continued From page 16 resident's environment. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide necessary care and services to ensure that two residents (R)3 and R13 abilities in activities of daily living did not diminish. The deficient practice affects the residents residing in the facility's ability to maintain the baseline ability to perform bathing, dressing, grooming and oral care. Findings include: 1) On 03/03/21 at 3:45 PM, surveyor reviewed the MDS admission evaluation for R3 dated 10/20/20 and quarterly review dated 01/21/21 and compared the scores. R3 declined in the following areas from a 1 on admission to a 2 at the quarterly: Eating: Initial- setup (1) to physical assist (2) at the quarterly assessment. Balance: Walking with assistive device; Initial - unsteady but able to stabilize without staff assistance; Quarterly - unsteady able to stabilize only with physical assist. Mobility device: Initial coded 0 for no wheelchair; to 1 for wheelchair at the quarterly assessment. 2) On 03/04/21 at 09:30 AM, surveyor reviewed the MDS annual assessment dated 10/24/20 and quarterly review dated 01/21/21 to compare functional abilities for R13. He declined in the following areas: Transferring: 3 to 4 (extensive assist to total dependence); personal hygiene: 2-3 (one person physical assist to two person physical assist; bathing: 2-3 (one person physical assist to two person physical assist).	4 177		

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4 177	Continued From page 17 Surveyor observed R13 getting ready for a shower with one RN and one CNA on 03/05/21 at 09:01 AM. Surveyor interviewed RN1 on 03/05/21 at 09:04 AM. When asked if R13 is receiving restorative care, she replied that the physical therapist (PT)1 works with him to help with his left arm, he wears a brace. When asked if there is a restorative aide here, she replied, "No more, we used to have a restorative aide. We are going to be bringing a restorative aide program to this facility." When asked who provided the restorative care to the residents, her response was, "The CNA's and RN provide the care when we have time. We do it when we provide their care and get them up. Stretching and ROM." Surveyor interviewed PT1 on 03/05/21 at 11:50 AM and asked how often does therapy screen the residents. "There is a screening every quarter, the unit clerk does the referrals to our PT department. Annually they are also evaluated. On the report, it's updated quarterly and annually." Surveyor asked what happens in between the quarterly evaluations if a resident starts to decline. PT1 stated, "The RN and I know if there is a significant level of change. She will let me know and I can check on them, do a screen, then we can ask for a PT trial for 1 week. I get a snapshot every quarter."	4 177		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the	4 203		

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4 203	Continued From page 18 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 and interview, the facility failed to designate an isolation room with contact precaution signs outside the room to alert staff not to enter the room without personal protective equipment and to check with the nurse before entering the room. The deficient practice places staff and residents at an increased risk of infection and illness. Finding includes: During an initial tour on the long-term care unit on 03/03/21 at 08:20 AM surveyor noted a negative pressure isolation room at the end of the hall on the right side. Inside the room in the bed R119 was sleeping. Noted a personal protective equipment (PPE) cart outside the door. Just inside the room on the left side by the door there were PPE gowns noted in a plastic bag. Outside the room there was no signage to indicate the room was an isolation room and staff entering needed to don PPE equipment. Surveyor interviewed the infection preventionist (IP) on 03/05/21 at 11:08 AM and asked when a resident is in an isolation room and on contact or droplet precautions, what type of signage is required to be placed on the door outside the room? The IP discussed the three different colored signs (blue, yellow and red) used for a resident or patient who is on isolation precautions. "If a resident or patient is being	4 203		

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4 203	Continued From page 19 ruled out for COVID-19 the blue stop sign would be placed on the negative pressure isolation room door located on the Medical surgical unit, intensive care unit (ICU,) and long-term care (LTC) unit. The sign should be posted outside the door to alert anyone entering the room to "stop" and enter the room only after donning (putting on) PPE gown, gloves and mask on before going in the room. It depends on what the resident is being monitored for which sign to place."	4 203		