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	(X3) DATE SURVEY COMPLETED
	125046	A. BUILDING: _____ B. WING _____	05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on interviews, record review, Policy and procedure, the facility failed to provide a safe environment for Resident (R) 174 which resulted in a fall with injury. R174 required hospitalization and surgery for her injury. Findings include: 1)R 174 sustained a fall with injury while left unattended in the restroom during a shower. R174 has a history of cerebral infarction, hemiplegia affecting left nondominant side. dysarthria. She has generalized muscle weakness and is unsteady on her feet. Record review of a facility reported event report on 05/12/21 revealed that R174 requested to use a shower chair that was too small for her size, and insisted to the certified nursing assistant (CNA)1 to place 3 blankets on the chair to make her sit higher on the shower chair. CNA1 told	4 136	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1. R174 is being showered in an appropriate chair for her size. R174 was inserviced by the DON on not using blankets/ towels/ etc. to sit on while in the shower chair and using unsafe equipment or procedures. Resident□s care plan was updated to reflect the use of an appropriate shower chair rated for her weight / size and not using any towels or blankets, etc to sit on. If resident wishes to use alternative methods to bathe, it was	6/28/21

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

Electronically Signed | 06/19/21

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4 136	Continued From page 1 R174 that this would be unsafe for her. CNA avoided more discussion because R174 would get upset with her. Although CNA1 did state that it was an unsafe shower chair, CNA1 did not get help from the assigned Registered Nurse (RN)17 who was the charge RN. Furthermore, the event report stated that CNA1 left the resident unattended during the shower three times, 1) while R39 was brushing her teeth, 2) CNA1 left to attend to R174's roommate and 3) to start to put away R174's shower belongings. At approximately 2015 on 04/24/21. CNA1 heard R174 yelling for help. Interview on 04/13/21 with RN17, stated that the night of the incident that R174 fell, CNA1 did not come and discuss the unsafe matter with her. She further stated that if the CNA1 had come to discuss this matter, she would not have allowed it. RN 17 showed me the shower chair that R174 sat on. R174 is reported to be approximately 205lbs and the shower chair was a small version, not the right size for someone of that weight. It was also noted by R 17 that there were three blankets placed on the shower chair at the time of the incident. This action propped the resident higher in the chair, making R174, at 205lbs, top heavy. This measure placed the resident at an unsafe risk for a fall. Record review of the job description for a certified nurse's aide, under safety and sanitation, (#14) Report all hazardous conditions and equipment to the charge nurse immediately. Record review of the job description of the Registered Nurse (RN) under essential functions, #12 states Communicates specifics of care for each resident to the C.N.A. Overseas care delivery by CNAs. Assists C.N.A.s as necessary.	4 136	agreed upon with resident and DON that she will discuss with the DON prior to her wanting to try the method to make sure it was safe for her. CNA 1 was re-inserviced regarding safety and reporting by the DON. R54 was reassessed for usage of a seatbelt. His/her orders, consents, care plan was updated as needed. (There is no resident 48 identified on the resident roster) 2. Facility residents requiring showering have the potential to be affected by this alleged practice. Facility residents using restraints have the potential to be affected by the alleged practice. 3.Direct care staff were reinserviced regarding appropriate showering techniques and reporting concerns to supervisors by the SDC /designee. Direct care staff were reinserviced regarding restraint usage and care planning by the SDC /designee. Inservices will be ongoing as needed. 4. DON / SDC / Unit managers /designee will monitor for compliance with showering techniques through observations on rounds 3 x weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved. DON / SDC / Unit managers /designee will monitor for compliance with restraint usage through observations on rounds and medical record reviews weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will	

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4 136	Continued From page 2 Record review of a competency checklist for CNA1 on giving a shower, (#14) states stay with the resident during the procedure for resident's safety. R174 sustained an unattended fall in the shower on 04/24/21 when she was left alone. In addition, R174 had insisted that she be placed in a shower chair that was "too small" for her and to add three blankets to be placed on the chair. This request placed R174 in an unsafe position in that the resident sat high above the armrests and had an unwitnessed fall. This deficient practice had the potential to affect the other residents identified in the facility 2)Based on observation, record review, and interview with staff members, the facility failed to provide ongoing monitoring for the continued use of a physical restraint to ensure the physical restraint is not used for staff convenience for Resident (R) 54. Findings Include: R54 was admitted to the facility on 02/27/20. Diagnosis include traumatic subdural hemorrhage without loss of consciousness, unspecified encephalopathy, unspecified dysphagia, unspecified dementia with behavioral disturbances, unspecified anxiety disorder, and other speech and language deficits following non traumatic subarachnoid hemorrhage. On 05/13/21 at 01:50 PM, observed R54 in his room with multiple attempts to stand up from his wheelchair with his seatbelt on. Certified Nursing Assistant (CNA) 48 and CNA56 entered R54's room and concurrently observed R54 attempt to	4 136	be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	

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4 136	Continued From page 3 stand up. CNA56 asked R54 if he is tired and if he wanted to go to bed. Surveyor inquired why R54 is wearing a seatbelt, CNA56 stated R54 wears a seatbelt because he keeps standing up. Surveyor observed the seat belt was taken off when he ate lunch and after lunch it was put back on. Review of physician's order prescribed on 06/17/21, "Okay for wheelchair seat belt PRN (as needed) for restlessness." On 05/14/21 at 10:13 AM observed R48 sitting in his wheelchair with his seatbelt on, no attempt to stand up from his chair or restlessness. Surveyor Interviewed Registered Nurse (RN) 19 on 05/17/21 at 11:00 AM, stated when R54 is restless the CNA(s) will inform her, and she will initiate the seatbelt restraint PRN. After the restraint is initiated, RN19 stated nursing staff monitor and remove the restraint every two hours. Inquired where is the monitoring and restraint release logged? RN19 stated she does not document the monitoring and does not know where to find the log. Interview with Resident Care Manager (RCM) 2 on 05/17/21 at 11:03 AM, stated she does not know where nursing staff log the monitoring of restraints and need to ask and get back to surveyor. Interview with Director of Nursing (DON) on 05/17/21 at 11:05 AM, stated nursing staff are to monitor residents with restraints and release the restraint every two hours. Inquired if there is a monitoring log for restraints, DON stated he will need to ask the RCM because they implement it with nursing staff and do the training.	4 136		

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4 136	Continued From page 4 Review of the CNA Job Description under Safety and Sanitation, "For residents who have restraint orders, retrain as instructed in chair/bed. Check restrained residents at least every 30 minutes. Release restraints at least every 2 hours and maintain record of times and duration restraints were released." Concurrent review of R54's Treatment Administration Record (TAR) with DON on 05/17/21 at 12:01 PM, on 05/13/21 at 10:55 AM the wheelchair seatbelt was initiated due to restlessness and was found effective at 12:04 PM. On 05/14/21 at 11:23 AM the wheelchair seatbelt was initiated due to restlessness and was found effective at 03:55 PM and noted at 10:47 PM effective "off at 20:00." Inquired whether "Effective" means the seat belt restraint was released, DON stated he did not know the answer and the record only shows when the restraint was given but not when it is taken off. DON further stated there is no other form used to document the monitoring of the restraint. The facility failed to review and revise R54's care plan to include the wheelchair seat belt as a physical restraint (refer F567).	4 136		
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.	4 148		6/28/21

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4 148	Continued From page 5 This Statute is not met as evidenced by: Based on observation, interview, and record review (RR), the facility failed to ensure there was enough staff to provide services and respond to each resident's needs in a timely manner, as evidenced by long call light wait times, complaints of cold food, and no staff at the Nurse's Station to answer the phone. As a result of this deficient practice, the residents experienced a decreased quality of life and were unable to attain their highest practicable well-being. Findings Include: 1) On 05/12/21 at 09:31 AM, an interview was done with Resident (R)50 in her room on Unit 1. R50 stated "the facility is understaffed," and explained that she has had to wait half an hour for the call light to be answered sometimes. As a result of having to wait, R50 said she has had to sit on the toilet or bedside commode for long periods, experiencing lower back pain from being in the same position for too long, she has had difficulty breathing while waiting for staff to come in to adjust her oxygen regulator, and she has had a bowel movement while in bed because she could not hold it any longer. Although she was wearing an incontinence brief at the time, R50 said she does not like to use it because she hates the feeling of sitting in a soiled brief. "[The] CNAs [certified nurse aides] are always busy with other residents, they gotta tube feed, gotta bathe residents, help residents to the bathroom, for meals they have to go to [the] kitchen and pick up [meal] trays and bring to the rooms." As a result, R50 said she is "told to wait a lot of times" when she calls for help, and sometimes gets her food cold. In addition to not providing timely resident	4 148	1. RD, RN 19, and unit manager were reinserviced on answering call lights by the SDC. Inservices will be ongoing as needed. Meal temperatures were monitored throughout the meal at time of survey and temperatures were within compliance. Hot food was at appropriate hot temperatures and cold food was at appropriate cold temperatures. Temperatures are taken with all meals and are appropriate. 2. Facility residents have the potential to be affected by the alleged practice. 3. Facility staff were reinserviced regarding answering call lights and phones by the SDC / Unit managers / designee. Inservices will be ongoing as needed. Dietary manager / DON / designee re-inserviced dietary staff and cnas regarding meal tray pass. Inservices will be ongoing as needed. 4. DON / SDC / Unit managers / Dietary manager / designee will monitor for compliance through call light observations on rounds and meal tray pass, auditing of food temperatures and resident interviews 3 x weekly for a minimum of 12 weeks or until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	

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4 148	Continued From page 6	4 148		

care, R50 complained that there is never any staff at the Nurse's Station to answer the phone, explaining that her sister had recently tried calling for three days to arrange drop-off of items for R50's birthday, but no one answered the phone. R50 stated she has discussed the insufficient staffing with the Minimum Data Set Coordinator (MDS), the Resident Care Manager (RCM)1, and the Director of Nursing (DON), and was told that "no one is applying."

2) On 05/12/21 at 10:55 AM, an interview was done with Resident (R)51 in his room on Unit 1. When asked about staffing, R51 stated that, "sometimes gotta wait long, sometimes [they] bring [the] food late." R51 explained that he has had to wait for half an hour sometimes before staff responds to his call light. As a result of insufficient staffing, R51 said that sometimes he gets his food cold, and he does not get to shower when he would like to but must wait for when staff has the time.

3) On 05/12/21 at 12:11 PM, during a dining observation in the Unit 1 Dining Room, it was noted that the CNAs were lined up at the kitchen pass-thru window waiting for lunch trays to be placed on the counter. As kitchen staff made each tray, they would place it on the counter where a CNA would cover the entire tray with cling wrap and deliver it to the appropriate resident one-by-one. There were no plate covers, or cup covers observed on the meal trays, only the cling wrap applied by the CNA. CNA73 was followed to Room 8 with a meal tray, and she was observed placing the meal tray on the resident's bedside table, washing her hands and wetting a washcloth at the sink, assisting the resident to wash their hands with the washcloth, then unwrapping their meal tray and setting it up

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4 148	Continued From page 7	4 148		

for them. CNA73 was then followed back to the dining room where she washed her hands again and waited for the next meal tray to deliver. This process of hand-carrying each meal tray one-by-one, from the kitchen to the resident's room, continued until meal service was done. It was noted that there was no kitchen staff available to cover the meal trays or expedite delivery in any way, and there were no tray carts used for transport.

4) On 05/12/21 at 01:24 PM, an interview was done with R2 in his room on Unit 1. R2 stated, "they're real shorthanded here, especially if you on this end [of the unit]." R2 explained that sometimes he has had to wait for forty-five minutes for staff to respond to his call for help. R2 said it is very frustrating that there is not enough staff to help, stating that sometimes he receives his meals cold, and if he did not ask for help to brush his teeth or wash his hands each morning, it would not get done. R2 also complained that there is never anyone at the Nurse's Station to answer the phone, stating that every time his brother or his nephews "call the front [Nurse's Station], nobody pick up."

5) On 05/12/21 at 04:00 PM, during a phone interview with R56's family representative (FR), FR expressed her concerns about sufficient staffing. FR stated, "every time I've called, no one picks up the phone." R56 is completely dependent on staff for all his needs, so FR likes to call the facility for updates on R56's condition frequently. FR said that she knows the facility is short-handed, and she worries that R56 is not getting the care he would be getting if she could visit him inside again. FR explained that before COVID she used to visit R56 weekly, and every week she had to brush his teeth due to a visible

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4 148	Continued From page 8 buildup of plaque. She has asked repeatedly for staff to be sure to brush R56's teeth daily but is doubtful that this is happening.	4 148		
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 (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 record review and interview with staff members, the facility failed to review and revise Resident (R) 54's care plan to include the wheelchair seat belt as a physical restraint. Findings Include:	4 149	1. R54 was reassessed for usage of a seatbelt. His/her orders, consents, care plan was updated as needed. 2. Facility residents using restraints have the potential to be affected by the alleged practice.	6/28/21

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4 149	Continued From page 9 R54 was admitted to the facility on 02/27/2020. Diagnosis includes traumatic subdural hemorrhage without loss of consciousness, unspecified encephalopathy, unspecified dysphagia, unspecified dementia with behavioral disturbances, unspecified anxiety disorder, other speech and language deficits following non traumatic subarachnoid hemorrhage, unsteadiness on feet, and muscle weakness (generalized). Interview with Certified Nursing Assistant (CNA) 56 on 05/13/21 at 01:50 PM, stated R54 wears a seatbelt in his wheelchair because he keeps standing up, the seat belt was taken off when he ate lunch and after lunch it was put back on. CNA56 further stated she believes the seatbelt restraint is in R54's care plan. Concurrent review of R54's care plan last revised on 04/27/21 with Director of Nursing (DON) on 05/17/21 at 01:12 PM, the care plan does not include the use of the wheelchair seatbelt as a physical restraint. Although the care plan addresses the prevention of falls by assessing " ...for use of WC (wheelchair) seat belt when restless," the care plan does not define and implement interventions during the use of the restraint, provide ongoing monitoring for the continued use, including the length of time the restraint is anticipated, who may apply the restraint, where and how the restraint is to be applied and used, and the time and frequency the restraint should be released. The care plan also does not address direct monitoring and supervision, including documentation of the monitoring. The facility failed to provide ongoing monitoring	4 149	3. Direct care staff were reinserviced regarding restraint usage and care planning by the SDC /designee. Inservices will be ongoing as needed. 4. DON / SDC / Unit managers /designee will monitor for compliance with restraint usage through observations on rounds and medical record reviews weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	

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4 149	Continued From page 10 and ensure a physical restraint is not used for staff convenience for R54 (refer F604).	4 149		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observations, interview with staff member, and review of the facility's policy and procedure, the facility failed to ensure a food product was discarded before the discard date. Findings Include: Review of the facility's policy and procedure for resident refrigerators, " ...nursing staff is responsible for discarding perishable foods on or before 3-day mark ..." Concurrent observation with Activities Manager (AM) on 05/12/21 at 12:01 PM, observed in Unit 2's nourishment room refrigerator, half of an egg sandwich saran wrapped in the refrigerator with a discard date of 05/11/21. AM stated the egg sandwich should not be in the refrigerator and needs to be discarded.	4 159	1. Activities manager, dietary manager and DON were re-inserviced regarding food storage in unit□s nourishment refrigerators by the SDC / designee. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by the alleged practice. 3. Dietary, Activity and Direct care staff were re-inserviced regarding the storage of food in the unit nourishment refrigerators by the SDC / designee. Inservices will be ongoing as needed. 4. DON / Dietary manager / Unit managers /designee will monitor for compliance through observations rounds 3 x weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement	6/28/21

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4 159	Continued From page 11	4 159	committee monthly for a minimum of 3 months or until compliance is achieved.	