STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125023	A. BUILDING _____ B. WING _____	07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANAI COMMUNITY HOSPITAL	628 7TH STREET LANAI CITY, HI 96763

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on 07/01/2021. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Census was 9. Sample size was 9.	F 000		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		7/21/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/21/2021

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F 842	Continued From page 1	F 842		

representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

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F 842	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interviews and record review (RR), the facility failed to ensure all resident's (R) medical records were complete and accurate. Four (R10 , R5, R6 and R8) records of the eight sampled did not contain documentation of all of the therapy exercises staff provided. Two (R5 and R6) of the eight sampled did not include consistent documentation of response to pain medication after it was administered. In addition, there was not consistency how the staff documented the post medication effectiveness and two methods were utilized. As a result of this deficiency it was difficult to see the effectiveness of the medication and important interventions of therapy were not documented and available for all caregivers. Finding include: 1) On 06/30/21 at approximately 12:40 PM, during an interview with the Occupational Therapist (OT), completed a RR for R5. The record revealed R5's most current order for therapy dated 06/30/21 read; "MEP (Maintenance Exercise Program) offer daily for AAROM (active range of motion)/PROM (passive range of motion) as tolerated." The Physical Therapy (PT) consult note (prior to the 06/30/21 order) dated 03/05/21 included "For MEP (maintenance exercise program), recommend ROM (range of motion) at B (both) LE's (Lower extremities) with overpressure to client tolerance into extension of 10 minimum BID (twice a day)." R5's Interdisciplinary Team Care Pan (CP) dated	F 842	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE CLIENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 6/30/2021, the Director of Nursing completed a review of records for residents R5, R6 and ensured that the pain medication was effective. On 6/30/2021, the Manager of Therapies completed a review of records for residents R10, R5, R6 and R8. The documentation process was reimplemented with staff to document all therapy exercises staff provide to the residents. HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: Documentation practices have the potential to affect all residents; therefore, correcting and standardizing correct practices is essential. On 6/30/2021, the Director of Nursing completed a review of all resident records to identify any other residents that had missing documentation of response to pain medication after it was administered. There were no additional records identified. All residents received a new baseline pain assessment. On 6/30/2021, the Manager of Therapies completed a review of all resident records to identify any other residents that did not have documentation of all the therapy	

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F 842	Continued From page 3 12/28/20 included the intervention; "PROM /AROM provided daily." The last time facility staff documented ROM exercises were performed with R5 was 03/09/21 at 08:20 AM. 2) On 06/30/21 at approximately 12:40 PM during an interview with the OT, completed a RR for R6. The record revealed R6 had an order dated 06/05/19 which read; "Maintenance Exercise Program PROM UE (upper extremities)/LE 5 (five) times per week." R6's CP dated 10/20/20 included the intervention; "PROM /AROM provided daily." The OT said although the order was written for five times per week, the staff do the exercises daily and are expected to document when they are done in the flowsheet of the electronic medical record. The last time facility staff documented ROM exercises with R6 was 05/08/21 at 09:47 AM. 3) On 06/30/21 at approximately 12:40 PM during an interview with the OT, completed a RR for R8. The record revealed R8 had an order dated 10/17/18 which read; "MEP UP to 5x (five times)/wk (week) for PROM." R8's CP dated 04/20/21 included the intervention; "Please provide daily ROM to prevent further contractures." The OT consult note dated 04/20/21 included; "ROM: B UE severe contractures cont (continue) recommend gentle ROM during care at this time ..." The last time facility staff documented ROM	F 842	exercises staff provided to the residents. There were no additional records identified. All exercise programs were reviewed. None of the exercise programs required revisions. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Director of Nursing developed an education training that instructs all licensed nurses to document the response to pain medication pre and post administration in the same designated location in the medical record (the medication administration record). On 7/21/21, all nurses were educated via in person lecture on where and when to document the response to pain medication after administration. The Manager of Therapies developed an education training that instructs all CNA's to document each time a prescribed therapy exercises is provided to residents. On 7/21/21, all CNA's were educated via in person lecture on where and when to document prescribed therapy exercises. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Weekly, the Director of Nursing will monitor for all residents the documentation of the response to pain medication after administration and documentation of all therapy exercises	

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F 842	Continued From page 4 exercises were performed with R8 was 05/17/21 at 08:00 AM. 4) R5's active diagnosis included chronic pain. RR revealed R5 had an order for Oxycodone 5 mg (milligram) tablet every six hours as needed for severe pain. In addition he had an order for Tylenol 650 mg orally every six hours as needed for pain/discomfort. Review of R5's Medication Administration Record (MAR) on 07/01/21 revealed he received two doses of Oxycodone on 06/28/21 and two doses on 06/29/21 for severe pain. The post medication pain scale was not documented on two of the four doses. Page two of the MAR, "Nurses Medication Notes" did not match the doses documented on page one. Page 2 has a "result code" legend for documenting R response to medication, which is E = Effective and I = Ineffective. Two of the doses did not have response documented R5 received Tylenol for pain three times on 06/28/21. The doses administered at "11:42 and 2245" did not have documentation of post medication pain scale. The documentation of pain scale on page one was not standardized. The premedication scale was numerical and the post medication score used the legend of effective or ineffective. 5) R6's active diagnosis included chronic pain. RR on 07/01/21 revealed she had orders for 640 mg Tylenol via GT (g-tube) every four hours as needed for breakthrough pain. Registered Nurse (RN)1 documented in her nursing note dated 06/20/21 at 02:07 AM that R6 was "Medicated with Tylenol 640 mg as ordered. Pt moaning..." Review of the Medication Administration Record (MAR) revealed what appeared to be two entries	F 842	provided by staff. Results of the weekly audits will be reviewed at the monthly QAPI meeting to ensure the corrective action is sustained. Validation at monthly QAPI meeting by Administrator.	

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F 842	Continued From page 5	F 842		

for Tylenol administration on 06/20/21 but was illegible. The MAR includes a section to document the pre-medication pain scale (0-10) and a section to document the post-medication pain scale. There was no pre or post pain scale documented for medication administered on 06/11/21 or the two times 06/20/21. In addition, there were no entries in the designated space on page 2 (Nurses Medication Notes) for these three times which is an expectation for documentation according to the Director of Nursing (DON).

On 06/27/21 at 03:21 AM, RN1 documented in R6's record "Tylenol given for constant moaning...unable to assess due to constant moaning." The nursing note did not include documentation of pre-medication pain scale, the amount or route of the Tylenol administered. At 05:00 RN1 documented "moaning subsided." There was no documentation of this dose being administered on the MAR.

Review of the facility policy titled "Pain Management" dated 08/19 included the following statements:
"Pain will be assessed utilizing the resident's self-report as the primary source of information and will include the resident's present level of pain."
"Appropriate non-communicative pain assessment tool will be utilized for resident's who are unconscious and unable to verbalize pain..."
"Effectiveness of analgesic medication will be assessed within an hour of administration depending on medication/route.

On 06/30/21 at approximately 01:30 PM, during an interview with the DON she validated it was an expectation and standard of nursing care that

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F 842	Continued From page 6	F 842		

staff document pre and post pain scales. She said the MAR was a document from PhaMerica and they have tried to utilize it to capture the data needed. The DON agreed several entries were difficult to read and that the pain documentation was not standardized and consistent.

6) Record Review (RR) on 06/29/21 at 10:16 AM was done. RR revealed that R10's documentation regarding daily mobility was inconsistent. It was not documented daily.

Interview on 06/30/21 at 1:00 PM with OT was done. OT stated that because the documentation is not consistent, daily mobility might be getting done but I agree the documentation needs to be improved. Therapist completed a RR for R10. Record revealed R10s most current order for therapy dated 04/22/21 read: "MEP (Maintenance exercise program) was to continue with daily MEP and PROM (passive range of motion) during care to prevent contractures.

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E 000	Initial Comments A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on 06/28/21 to 07/01/21. The facility met the Health Safety Requirements of Appendix "Z", for emergency preparedness and response; in accordance with 42 CFR 483.73 requirement for Long term care facilities.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/21/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	INITIAL COMMENTS THIS FACILITY MET THE REQUIREMENTS OF THE 2012 EDITIONS OF: NFPA 99, HEALTH CARE FACILITIES CODE AND NFPA 101, LIFE SAFETY CODE, CHAPTER 19, EXISTING HEALTH CARE OCCUPANCIES.	K 000		

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E 000	Initial Comments THIS FACILITY MET THE LIFE SAFETY REQUIREMENTS OF APPENDIX "Z"; IN ACCORDANCE WITH CFR 483.73, REQUIREMENT FOR LONG-TERM CARE (LTC) FACILITIES	E 000		

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