STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET 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 was conducted in conjunction with the recertification survey by the Healthcare Management Solutions, LLC on behalf of the Hawaii Department of Health, Office of Health Care Assurance on October 26, 2021. The facility was found not to meet the regulatory requirements for Hawaii Administrative Rules, Title 11, Chapter 94.1, Nursing Facilities.	4 000		
4 025	11-94.1-2 Definitions As used in this chapter: "Licensed social worker" or "social worker" or "LSW" means a person who is licensed to practice social work pursuant to chapter 467E, HRS. This Statute is not met as evidenced by: Based on employee record review and interview with staff member, the facility did not ensure the Director of Social Services and social workers met the definition of a social worker pursuant to Chapter 467E. Findings include: A request was made for licensure information related to the credential expiration date for the Social Services Director (SSD). On 11/04/21 at 10:46 AM, the Administrator reported the SSD does not have a license, the SSD is a Bachelor's prepared social worker without a license. The Administrator confirmed the facility does not have licensed social workers on staff. Also, the Administrator confirmed the facility does not have a contract with a licensed social worker to	4 025	Point 1: How corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified to have been affected by this deficient practice. The facility will have a Licensed Social Worker as a consultant to provide supervision and oversight of the Social Services department until a license can be obtained by in-house staff. Point 2: How the facility will identify other residents having the potential to be affected by the same deficient practice. No residents were identified to have been	12/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET 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
4 025	Continued From page 1 supervise the social worker department. The facility provided a copy of the job description for the SSD on 11/04/21 at 11:27 AM. The position entails planning, organizing, developing, and directing the overall operation of the Social Services department to ensure all medically-related emotional and social needs of patients are met in accordance with all applicable laws, and reports to the Executive Director. Further review notes: "must be currently registered/licensed in application State (if required by State law). Must maintain an active license in good standing throughout employment" and "must have a bachelor's degree in a human services field (which may include gerontology) if working in a facility with 120 ore more beds (see State law)." A review of Chapter 467E defines a social worker as "person who has been issued a license as a licensed bachelor social worker, licensed social worker, or licensed clinical social worker to practice within the scope of practice as provided in this chapter." In Section §467E-5, no person shall purport to be a "social worker" without meeting the applicable requirements and holding a license. A review of Section §467E-6 regarding exemptions, found the facility's social workers does not meet exemption criteria.	4 025	affected by this deficient practice. Point 3: What measures was put into place or systemic changes made to ensure that the deficient practice will not recur. The facility will have a Licensed Social Worker as a consultant to provide supervision and oversight of the Social Services department until a license bachelor of social worker can be obtained by in-house staff. The Director of Social Services (DSS) submitted her application on 11/17/21, for the license bachelor of social worker. The DSS will ensure she or a member of her staff will obtain and maintain an active license bachelor of social worker. Point 4: How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. The Executive Director or her designee will monitor for compliance the next 30 days. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting until the QAPI committee determines that further review is no longer necessary. Point 5: Date corrective action will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET 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
4 025	Continued From page 2	4 025	completed. December 3, 2021.	
4 095	11-94.1-20(a) In-service education (a) There shall be a staff in-service education program that includes the following: (1) Orientation for all new employees that shall include: (A) Information to acquaint them with the philosophy, organization, program, policies and procedures, practices, and goals of the facility; and (B) Competency evaluation to ensure that staff are able to carry out their respective duties; (2) In-service training for employees who have not achieved the desired level of competence, and continuing in-service education to update and improve the skills and competencies of all employees; (3) In-service training that shall include annually, at minimum, prevention and control of infections, fire prevention and safety, disaster preparedness for all hazards, accident prevention, resident rights including prevention of resident abuse, neglect and financial exploitation, and problems and needs of the aged, ill, and disabled; (4) Competency testing for cardiopulmonary resuscitation to annually certify the nursing staff; (5) Training in oral hygiene and denture care,	4 095		12/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET 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
4 095	Continued From page 3 which shall be given to the nursing staff at least annually; and (6) Appropriate personal hygiene instructions at regular intervals shall be given to all personnel providing direct care and handling food. This Statute is not met as evidenced by: Based on review of staff in-service training records and interview with staff members, the facility failed to ensure mandatory annual training was done for 8 of 12 randomly selected staff members. The facility did not assure 7 of 7 nursing staff completed annual training in oral hygiene and denture care. Findings include: On 11/04/21 at 12:00 PM interview and review of staff members' inservice training records were done with Registered Nurse Staff Development Coordinator (RNSDC). The coordinator reported due to the pandemic, group training ceased. The RNSDC reported training is also available online and staff members are required to print their certificates and submit for recording. Review of staff members' records found eight staff members did not complete the following required training, fire and safety, accident prevention, and need of ill, aged, and disabled. The RNSDC confirmed oral hygiene and denture care is required for certified nurse aides and licensed nursing. RNSDC reported dental training was not done this year.	4 095	Point 1: How corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified to have been affected by this deficient practice. By 11/9/21, the eight staff members completed the following required training: fire and safety; accident prevention; and the need of ill, aged, and disabled. By 11/9/21, the seven nursing staff members completed the dental care training. Point 2: How the facility will identify other residents having the potential to be affected by the same deficient practice. No residents were identified to have been affected by this deficient practice. The Registered Nurse Staff Development Coordinator (RNSDC) or her designee will ensure other staff complete the required training for fire and safety; accident prevention; the need of ill, aged, and disabled; and dental care by November 30, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET 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
4 095	Continued From page 4	4 095	Point 3: What measures was put into place or systemic changes made to ensure that the deficient practice will not recur. RNSDC was provided education on 11/16/21 on the importance of ensuring staff completion of the State mandatory in-services annually as well as how to pull reports from the facility□s online education system. The RNSDC will develop an annual calendar with the State mandatory education required topics and complete tracking of staff on a monthly basis. Point 4: How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. The RNSDC or her designee will complete weekly reviews on the mandatory ins-services of staff for the next 30 days. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting until the QAPI committee determines that further review is no longer necessary. Point 5: Date corrective action will be completed. December 3, 2021	
4 136	11-94.1-30 Resident care	4 136		12/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET 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
4 136	Continued From page 5 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 record review, policy review, observation, and resident and staff interviews, the facility failed to ensure two Residents (R) R5 and R6 of three residents who were reviewed for positioning and mobility were provided with restorative services per their plan of care. R5 and R6 did not receive assistance to apply their splints per their plans of care, creating the potential for pain, skin breakdown, or contracture development. Findings include: 1. Review of the facility's "Restorative Nursing Policy" dated 08/07/21 revealed, "The facility is responsible for providing maintenance and restorative programs as indicated by the resident's comprehensive assessment to achieve and maintain the highest practicable outcome;" and "Restorative Nursing can be within one of the following categories: ... Splint or brace	4 136	Point 1: How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 10/21/2021 charge nurse assured splints for R-5 and R-6 were placed. On 10/21/2021 resident R-5 and R-6 order and care plan were reviewed and revised for nursing to don/doff splints. On 10/21/2021 direct staff on North 2 unit were educated on application of splints by nursing staff. Point 2: How the facility will identify other residents having the potential to be affected by the same deficient practice. On 11/01/2021 an audit was completed for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET 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
4 136	Continued From page 6 assistance." Review of R5's undated "Resident Face Sheet," located under the "Admissions" tab of the Electronic Medical Record (EMR) revealed he was admitted to the facility on 02/24/14 with diagnoses including personal history of traumatic brain injury. Review of R5's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 07/08/21 revealed R5 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 99, indicating the assessment could not be completed due to the resident's poor cognition. Further review of the assessment revealed R5 range of motion (ROM) impairment to his upper and lower extremities on one side of his body, and that a splint or brace was not in use. Review of R5's "Activities of Daily Living (ADL) Care Plan," dated 10/12/21 and found in the EMR under the Care Plan Tab, revealed the resident had ADL self-care and mobility limitations related to his history of traumatic brain injury and, "Please don B-palm guards at beginning of AM shift and doff at end of AM shift for skin integrity and contracture management. Remove all upper extremity splints at end of day shift;" and "Apply splinting device to affected extremity daily per protocol/physician order: remove splint daily for inspection/cleaning of skin and gentle ROM" Review of R5's "Order Listing Report", dated 10/2021 and provided by the facility, revealed an order for the resident to have a left elbow/forearm splint and a right palmer/wrist splint applied daily for five hours as tolerated.	4 136	all residents who utilizes splints to ensure orders/care plans were accurate. On 11/01/2021 audit of skin checks were done for all residents who utilize splints. On 10/31-11/3/2021 an audit was completed for all residents who has orders/care planned to don splints were applied as ordered/care planned. On 11/01/2021 Occupational screens were sent for all residents who utilize splints to identify any or worsening contracture development. Point 3: What measures was put into place or systemic changes made to ensure that the deficient practice will not recur. On 11/02/2021 Splint applications were added to Point of Care as a task for CNA□s daily documentation. On 11/03/2021 Licensed staff received targeted in-service education on following orders/care plans for splint application. On 11/03/2021 Certified nurse aides received targeted in-service education on following orders/care plans for splint application. Documenting on Point of Care tasks for splint applications. Point 4: How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET 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
4 136	Continued From page 7 R5 was observed in his bed on 10/19/21 at 10:30 AM. The resident was observed to have bilateral contracted hands. No splinting device was observed on either of the resident's upper extremities. The resident was observed in bed in his room on 10/19/21 at 11:36 AM. The resident was not observed to be wearing any type of splinting device to his upper extremities. R5 was observed in his bed on 10/19/21 at 2:50 PM. The resident was not wearing splints on his upper extremities. The resident was observed on 10/20/21 at 8:57 AM. The resident was in his room in bed. He was not wearing splints on either of his upper extremities. R5 was observed in his bed on 10/20/21 at 1:53 PM. He was not wearing splints on either of his upper extremities. 2. Review of R6's "Resident Face Sheet" located under the "Admissions" tab of her EMR revealed she was admitted to the facility on 01/29/19 with diagnoses including history of stroke and hemiparesis/hemiplegia following the stroke. Review of R6's quarterly MDS with an ARD of 07/08/21, revealed R6 was severely cognitively impaired with a BIMS score of 99, indicating the assessment could not be completed due to her poor cognition. The assessment indicated R6 had both short and long-term memory impairment. The MDS indicated R6 had ROM impairment to her upper and lower extremities on one side of her body, and that a splint or brace was not in use.	4 136	effectiveness of the systemic changes. DON/designee will audit 5 residents for splint application weekly to ensure proper application of splinting devices are applied for the next 30 days. The results of the reviews will be presented at the Quality Assurance and Performance Improvement Committee (QAPI) meeting until the QAPI committee determines that further review is no longer necessary. Point 5: Date corrective action will be completed. December 3, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET 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
4 136	Continued From page 8 Review of R6's "Activities of Daily Living Care Plan", dated 10/12/21 and found in the EMR under the Care Plan Tab, indicated the resident had ADL self-care and mobility limitations related to her history of stroke and read, "Day shift nursing to don right soft palm guard splint at the beginning of shift and doff at the end of shift as tolerated;" and "Nursing to don right upper extremity splint in the morning and doff right upper extremity splint between lunch and end of day shift." Review of R6's "Order Listing Report", dated 10/2021 and provided to the survey team, revealed an order for the resident to wear a right wrist hand orthotic and right elbow pillow splint for six to eight hours daily on the day shift. R6 was observed on 10/19/21 at 10:01 AM while lying in her bed. The resident was observed to have contractures to her upper left extremity. No splint was in place on the resident's right upper extremity. R6 was observed in bed on 10/19/21 at 03:04 PM. The resident was not wearing a splint on her right upper extremity. R6 was observed in bed on 10/20/21 at 9:30 AM. The resident was not wearing a splint on her right upper extremity. The resident was observed in bed on 10/20/21 at 2:04 PM. The resident was not observed to be wearing a splint. During an interview with Licensed Practical Nurse (LPN) 1/Unit Manager on 10/21/21 at 12:25 PM, she stated that R5 and R6 were supposed to be	4 136		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET 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
4 136	Continued From page 9 wearing the ordered splints during the day. She stated the splints were to be applied in the morning and removed at the end of the shift, which was at 2:00 PM. LPN1 stated that the Restorative Nursing staff was responsible for applying the splints at the beginning of the day shift. She stated, "The splints are supposed to be on." During an interview with the Restorative Nursing Manager/Assistant Director of Nursing (ADON) on 10/21/21 at 1:36 PM, she verified the splinting orders for R5 and R6 and stated nursing staff was responsible for applying and removing the splints. She stated nursing should be applying the splints every day. She stated the facility's restorative program had been on hold temporarily due to the COVID pandemic, however nursing staff was still responsible for ensuring R5 and R6's splints were applied. During an interview with the Director of Nursing (DON) on 10/22/21 at 9:35 AM, she stated her expectation was that splints were to be applied for residents as ordered and per their plan of care.	4 136		