STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HI02LTC5064	A. BUILDING: _____ B. WING _____	01/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOA COTTAGE - KAIMUKI	748 OLOKELE AVENUE HONOLULU, HI 96816

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4 000	Initial Comments An abbreviated survey was conducted by the state agency on 01/21/21. Aspen complaint tracking system (ACTS) complaint #8653 was investigated and substantiated. The facility was found not to be in compliance with Hawaii administrative rules Title 11 Department of Health Chapter 94.1 Nursing Facilities.	4 000		
4 105	11-94.1-22(g) Medical record system (g) All entries in a resident's record shall be: (1) Accurate and complete; (2) Legible and typed or written in black or blue ink; (3) Dated; (4) Authenticated by signature and title of the individual making the entry; and (5) Written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical doctor. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to document accurately and completely in the medical record's of two residents in the sample. The deficient practice failed to show a clear picture of what, when and how actions were taken for care that was provided for one resident (R)1, who transferred to the emergency department after aspirating emesis and later developed sepsis.	4 105		

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4 105	Continued From page 1 Findings include: Surveyor reviewed the medical record for resident (R)1 on 01/20/21 at 01:30 PM. Nurses note dated 06/27/20 "Resident is combative towards the staff...Walked with him in the restroom and put him in bed". The next nurses notation begins on the same page dated 08/05/20 03:00 "with an unwitnessed fall". Surveyor noted no nurses notes for month 07/2020. Surveyor reviewed the medical record for R2 on 01/21/21 at 10:00 AM. R2 was admitted to facility on 10/23/19. Surveyor noted the weekly summary/monthly summary box was not checked for following dates: 01/25/20; 02/26/20; 03/28/20; 04/22/20; 05/27/20 06/24/20. Surveyor reviewed a late entry nurses note in R1's medical record dated 08/27/20 at 1830; small amount of vomit @ 1500, alert vital signs (VS) 98.1, 124/79, 80, 28. 90% on room air (RA) @1515 sleeping, no vomit. Recheck VS 98.4, 235/94 heart rate (HR) 162 by machine, respiratory rate (RR) 40. Oxygen (O2) up to 70% on RA, small amount of coffee ground emesis noted... Surveyor noted retook vitals on 08/27 but no time was documented at the time vitals were taken when the resident had a very high blood pressure and a very low O2 saturation and eventually was transferred to the emergency department at 1815. (Cross reference: 0149). Surveyor asked the DON what is the expectation of the nursing staff to document completely and accurately in the medical record, how often, where and by whom and how is it being	4 105		

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4 105	Continued From page 2 monitored? The DON responded that any change in the residents condition should be documented in the nurses notes. Any new orders from the doctor should be documented in the nurses notes. We have a medical record technician and does quarterly audit's to check the records are complete, accurate and legible. I ask the help of the nurses to check if there is anything missing or not documented. (CR: 0149).	4 105		
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:	4 149		

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4 149	Continued From page 3 Based on interview and record review, the facility failed to monitor resident (R)1 for aspiration precautions and accurately document in the medical record critical information about the residents status. A change in R1's condition that he was having difficulty swallowing was not reported to the doctor, and vital signs that indicated a very high blood pressure and very low oxygen saturation was not documented with a time. The deficient practice placed R1 at a high risk for aspiration and severe illness. Findings include: Surveyor reviewed the complaint #8653. Complainant was concerned that on 08/27/20, R1 was left alone in his room at the facility and not closely monitored after he started throwing up. Complainant stated that she felt if R1 was taken to the hospital earlier he might have lived. Complainant doesn't want this to happen to anyone else, adding that if an elderly patient is throwing up they need to be watched more closely. Surveyor reviewed the medical record on 01/20/21 at 12:30 PM. Death note dated 09/09/20 by primary care doctor (PCP), R1 died while in hospice on 09/07/20. Prior he initially was taken by emergency medical services (EMS) to emergency department on 08/27/20. EMS found him with an oxygen saturation (SpO2) of 50%, which improved to 90% after Ambu-bag treatment, He was found to be in severe sepsis with acute respiratory failure. He was stabilized then transferred to another acute care hospital where he was treated with a full course of intravenous (IV) antibiotics and IV fluids with apparent resolution of his aspiration pneumonia. He remained on supplemental oxygen. During	4 149		

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4 149	Continued From page 4 his recent hospitalization, he was delirious and had a profound dysphagia (difficulty swallowing). He failed his modified barium swallow (MBS) test on 09/01/20 and continued to require deep suctioning due to apparent aspiration of saliva... Surveyor reviewed the following nurses notes for R1: 08/06/20 at 1400 Resident noted leaning on right side. No apparent injury from previous fall. Neuro check within normal limits (WNL). Up this morning for breakfast and lunch. No complaint of (C/O) discomfort will continue to monitor. 08/06/20 at 2000 Status post (S/P) fall Appears difficulty swallowing and leaning to right side significantly. No complaint of pain or any discomfort. Less standing up from wheelchair (WC), able to follow simple commands. Surveyor noted no documentation by the registered nurse (RN) to indicate the physician (MD) was made aware of residents change in condition. 08/11/20 at 2000 "Resident appears general weakness, runny nose, drooling and difficult eating and swallowing. Given crushed meds by RN. Not walking with walker. After dinner resident lying in bed. No complaint of pain or any distress." Surveyor noted the documentation did not indicate the condition was reported to the MD. 08/27/20 at 02:30 AM "Resident had nausea while certified nurse aide (CNA) rounds being done and had emesis of undigested food. Moderate amount. Took resident showered him, states, feel better after shower. Able to drink full glass water. Continue to monitor status." 08/27/20 at 10:55 "Re: vomiting called MD, resident had emesis after breakfast. Food particles. No C/O stomach ache or discomfort @ this time... Continue to monitor."	4 149		

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4 149	Continued From page 5 08/27/20 at 11:30 Give Zofran (an anti-nausea medication) 4 mg per MD. Will continue to monitor. Noted documentation did not specify R1 was being monitored for aspiration or emesis." 08/27/20 at 1830 "small amount of vomit @ 1500, alert vital signs (VS) 98.1, 124/79, 80,28. 90% on room air (RA) @1515 sleeping, no vomit. Recheck VS 98.4, 235/94 heart rate (HR) 162 by machine, RR 40. Oxygen (O2) up to 70% on RA, small amount of coffee ground emesis noted. Call to after hours acute care hospital office and reported the residents condition to RN who recommended to call 911. RN called 911 and power of attorney (POA) accepted to send resident to ER. Paramedics states "critical condition, send him to nearest emergency department. Left the message to POA 1 and POA 2 Resident left at 1815. RN reported this event to Director of Nursing (DON)." Surveyor noted retook vitals on 08/27 but no time documented at the time vitals were taken when the resident had a very high blood pressure and a very low 02 saturation. Late entry on note 1830 that resident went to acute care hospital via EMS. (Cross reference (CR) 0105). Surveyor interviewed the Director of Nursing (DON) on 01/22/21 at 11:00 am in the 2nd floor conference room. Surveyor asked the DON how does she ensure the nursing staff are following the nursing care plan, and how is the care planning process being monitored? The DON responded that she writes the care plan's for the residents and periodically talk's to the charge nurse to see if the care plan needs to be updated or changed. Surveyor asked if a resident has a new onset of	4 149		

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4 149	Continued From page 6	4 149		

emesis, how often would the nursing staff make rounds on the resident, and would they be placed on aspiration precautions? The DON responded for emesis, if a resident threw up the nurse would make sure the resident will have the head of bed elevated and checked on every 30 minutes. If the previous order from the doctor includes an as needed (PRN) medication we will give it. We would report to the doctor if the medication is not effective. The close monitoring is a team effort.

Surveyor asked the DON when would the nursing staff call a doctor if a resident has a change in condition like difficulty swallowing, coughing weakness? The DON responded that she would call the doctor right away after the assessment if there were any abnormalities.

Surveyor asked the DON what is the expectation of the nursing staff to document completely and accurately in the medical record, how often, where and by whom and how is it being monitored? The DON responded that any change in the residents condition should be documented in the nurses notes. Any new orders from the doctor should be documented in the nurses notes. We have a medical record technician who comes in to do quarterly audit's, to check the records are complete, accurate and legible. I ask the help of the nurses to check if there is anything missing or not documented. (CR: 0105).

Surveyor asked the DON if the Resident's condition was documented as being "critical", should the resident have been transported earlier than 1815? The DON responded that Yes, he should have.

Surveyor asked the DON if R1 was being

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4 149	Continued From page 7 monitored for aspiration precautions? She responded that the RN should have been monitoring the resident closer, every 30 minutes, placing him on his side, as a precautionary. After looking in the care plan and nurses notes the DON responded that it was not documented in the nurses notes or care plan that R1 was on aspiration precautions and being frequently monitored. (CR: 0105).	4 149		