| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125021 | A. BUILDING _____ B. WING _____ | 09/22/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| KAUAI VETERANS MEMORIAL HOSPITAL | 4643 WAIMEA CANYON DRIVE WAIMEA, HI 96796 |

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| F 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 09/19/23 - 09/22/2023. The facility was found not to be in substantial compliance with 42 CFR §483, Subpart B.<br><br>Survey Dates: 09/19/23 - 09/22/23<br><br>Survey Census: 20 | F 000 | | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when- | F 623 | | 11/6/23 |

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

Electronically Signed | 11/02/2023

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| F 623 | Continued From page 1 | F 623 | | |

(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part

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| F 623 | Continued From page 2<br>C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure that the family or resident representative of one resident (R)19, out of three residents sampled, was notified of R19's transfer to the emergency room (ER) for an acute condition. This deficient practice fails to protect residents from possible inappropriate facility-initiated discharges from the facility. | F 623 | 1. Social Worker notified Kauai□s Ombudsman Office on 9/22/2023 that patient R19 had been transferred to the Emergency Department on 8/13/2023. Family had been notified previously by phone on day of transfer, but a letter was not sent. A late letter in response to this citation was not sent to the family because this resident expired prior to CMS coming | |

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| F 623 | Continued From page 3<br>Finding includes:<br><br>On 09/21/23 at 11:54 AM, progress notes revealed that R19 was transferred to the ER due to a low blood count.<br><br>On 09/22/23 at 11:11 AM, conducted a concurrent observation of R19's electronic health record (EHR) and interview with the MDS Coordinator (MDSC) at the nursing station. MDSC confirmed that R19 was transferred to the ER on 08/13/23 as evidenced by an ER physician note documented on 08/13/23 at 09:21 AM that R19 refused her hemodialysis treatments (medical process to clean toxins out of the blood and to remove excess fluids) on Friday and Saturday. Progress notes revealed further that R19 was transferred from the ER to the intensive care unit (ICU) on 08/13/23 at 01:59 PM. There was no documentation in the progress notes found about a written notification being sent to R19's family.<br><br>On 09/22/23 at 12:18 PM, interviewed the Social Worker (SW) in her office. SW stated that no written notification are sent to the resident representative or Long Term Care Ombudsman for residents that are transferred to another provider for higher levels of care. | F 623 | to survey our facility.<br>2. All residents who are transferred or discharged have the potential to be affected by this deficient practice.<br>3a. Notice of Resident Transfer/Discharge letter template and Resident Transfer and Discharge Policy were created.<br>3b. Education regarding Policy #550-106-2 and the letter template have been initiated and will be completed by 11/6/2023.<br>3c. Education will be provided to new LTC RN hires during their orientation.<br>4a. LTC DON will review and track all transfers to validate that appropriate notifications (both immediate verbal and letter) were provided to the resident, their representative and Kauai□s Ombudsman in accordance with the policy.<br>4b. LTC DON will report monthly findings from her reviews to HPIC for the next three consecutive bi-monthly meetings. | |
| F 638 SS=D | Qrtly Assessment at Least Every 3 Months<br>CFR(s): 483.20(c)<br><br>§483.20(c) Quarterly Review Assessment<br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br>This REQUIREMENT is not met as evidenced by: | F 638 | | 10/31/23 |

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| F 638 | Continued From page 4<br>Based on interview and record review, the facility failed to ensure that quarterly comprehensive assessments were completed no less frequently than once every 3 months for 2 of 2 residents (R) in the sample. As a result of this deficient practice, the facility placed R1 and R16 at risk of not having their needs met. This deficient practice has the potential to affect all the residents at the facility for long-term care.<br><br>Findings include:<br><br>On 09/21/23 at 03:00 PM, during a review of Resident (R)1's electronic health record (EHR), it was noted that R1's last quarterly Minimum Data Set (MDS) assessment had been completed on 05/20/23. The most recent MDS assessment showed an assessment reference date (ARD) or target date of 08/17/23, but had not been completed.<br><br>On 09/21/23 at 03:24 PM, an interview was done with the MDS Coordinator (MDSC) at the Nurses' Station. Reviewing a Final Validation Report provided by the MDSC, it showed the assessment due on 08/17/23 had a "Completion Date" of 09/21/23. The MDSC confirmed that some of the care area assessments had been completed more than 14 days after the ARD, making them late. The MDSC also verified that the completion date of 09/21/23 was correct, making the assessment more than 92 days since the last. | F 638 | 1. The delinquent Quarterly MDS Assessments on R1 and R16 were successfully submitted on 9/21/23.<br>2. All residents do have the potential to be affected by this deficient practice.<br>3a. LTC DON verbally counseled the MDS Coordinator on 9/22/23 on the requirements for timely MDS completion and submission. MDS Coordinator was also instructed to seek assistance from the LTC DON or CNE when timely submission is in jeopardy.<br>3b. LTC DON and MDS Coordinator developed a manual MDS Submission Calendar that will be utilized to track the due dates and submission dates for all MDS resident assessments.<br>3c. Cerner Community Works Electronic Medical Record (EMR) system has MDS Intelligence Software that is integrated for easier and more accurate recording and reporting of MDS assessments. In the case of these two residents, submission dates did not match actual due dates. The MDS Coordinator will validate that the submission dates in the EMR are correct utilizing the MDS Submission Calendar with oversite by LTC DON monthly.<br>3d. MDS Coordinator reviewed Cerner MDS Intelligence Software Training that was available in Cerner Wiki Links on Oct 31, 2023.<br>4a. LTC DON will monitor MDS assessments monthly for timely submissions for the next six months and/or until 100% compliance achieved, then quarterly thereafter.<br>4b. LTC DON will report findings from the monthly monitoring to HPIC for the next | |

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| F 638 | Continued From page 5 | F 638 | three consecutive bi-monthly meetings and/or until 100% compliance is achieved. | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure one resident (R) in the sample was free from accident hazards. Despite being unsteady on her feet and requiring at least a two-man assist to stand, staff failed to lock R11's shower chair before having her stand for a transfer, placing her at risk for an avoidable fall and/or injury. This deficient practice has the potential to affect all residents at the facility who require assistance to stand or transfer.<br><br>Findings include:<br><br>Resident (R)11 is an 80-year old female admitted to the facility on 02/14/23 with admitting diagnoses that include age-related physical disability, Diabetes, Hypertension (high blood pressure), Heart Failure, and Morbid Obesity.<br><br>A review of R11's most recent quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 08/13/23, shows that for | F 689 | 1. LTC DON did immediate verbal education with staff involved on 9/22/2023. Staff were able to verbalize understanding of the importance of locking movable equipment to maintain resident safety during transfers.<br>2. All residents that need assistance to stand or transfer have the potential to be affected by this deficient practice.<br>3a. LTC DON monitored resident□s needing assistance to stand or transfer from shower chair to wheelchair from 9/22/23 to 9/29/23 to determine if any other safety issues existed as a result of this same practice. No other issues were found.<br>3b. The LTC DON completed education for the LTC staff regarding Activities of Daily Living (ADL) and resident safety practices including the requirement to lock all movable equipment prior to transfer. CNAs were instructed to ask for assistance with transfers. A return | 11/6/23 |

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| F 689 | Continued From page 6<br>Balance During Transitions and Walking, as well as Surface-to-Surface Transfer (transfer between bed and chair or wheelchair), R11 was marked as "Not steady, only able to stabilize with human assistance." Further review noted that under Mobility, for Sit to Stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed; and for Chair/bed-to-chair transfer: The ability to safely come to a standing position from sitting in a chair or on the side of the bed, R11 had been marked as needing "Substantial/maximal assistance - Helper does MORE THAN HALF the effort."<br><br>On 09/20/23 at 09:34 AM, an observation was done at R11's bedside. Registered Nurse (RN)6 had just completed a dressing change on a wound to R11's left shin following her shower. RN6, Certified Nurse Aide (CNA)9 and CNA8 were preparing to transfer R11 from the shower chair she was sitting on, to her wheelchair, however R11 still needed to don (put on) an adult disposable brief and her pants. Prior to having her stand, CNA9 stated "she made doo-doo (defecated) [in the shower], she still get," and grabbed some moistened absorbent wipes. As RN6 and CNA8 got ready to assist R11 from sitting in the shower chair to standing, CNA8 suggested using a gait belt. CNA9 stated, "no, she no like." As RN6 and CNA8 grabbed R11 under either armpit, an observation was made that the shower chair, with CNA9 standing by, had not been locked. Surveyor asked, "do you want to lock the shower chair [to keep it from moving]," to which CNA9 responded "no, I need to move it fast that's why." RN6 and CNA8 had R11 grasp the bed rail while they assisted her to stand. As she stood, CNA9 moved the shower chair out of the way, wiped R11's buttocks with | F 689 | demonstration was required with emphasis on locking movable equipment. Locking movable equipment for transfers had been added as an annual competency for LTC Nursing staff.<br>4a. LTC DON will audit 10 transfers from movable equipment each month for six months to validate compliance. Immediate re-education will be done with progressive counseling for any non-compliance observed.<br>4b. LTC DON will report findings from the monthly monitoring to HPIC for the next three consecutive bi-monthly meetings and/or until 100% compliance is achieved. | |

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| F 689 | Continued From page 7<br>the absorbent wipes, pulled R11's adult disposable brief and pants up (all while positioned behind her), then moved her wheelchair into place where RN6 and CNA8 helped her sit. Upon further questioning regarding the safe transfer of residents, RN6 and CNA9 reported that R11 is normally a 2-person assist for transfers. Since there were three staff members present however, they did not/do not lock the chair she is transferring from because they need to move it out of the way quickly "because she [R11] cannot stand long." CNA9 further explained that because they used three people for the "quick transfer," they didn't lock the shower chair, but they "usually do" when transferring other residents.<br><br>On 09/22/23 at 10:18 AM, an interview was done with the Director of Nursing (DON) in her office. The DON explained that the staff members had shared the incident with her. After the Surveyor described the observations made on 09/20/23, the DON stated it was her understanding that it was a quick transfer, meaning the shower chair was immediately switched out for the wheelchair and the resident was seated. Given the length of time R11 stood while her buttocks were wiped and her brief and pants were pulled up, the DON agreed that the shower chair should have been locked for safety. Upon further discussion, the DON agreed that all movable equipment should be locked for safety during transfer. | F 689 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must - | F 812 | | 11/2/23 |

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| F 812 | Continued From page 8<br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and record review, the facility failed to provide safe storage for delivered food items placed into the kitchen's chiller and the dietary aides failed to perform appropriate hand hygiene while delivering meal trays to residents. These deficient practices have the potential to cause harm to their residents, staff, and visitors due to the possibility of contracting a food borne illness.<br><br>Findings include:<br><br>1) On 09/19/23 at 10:32 AM, conducted a concurrent observation and interview with the kitchen chef (KC) of the kitchen's chiller located outside, across from the freezer. The chiller contained a box of sour cream tubs on the floor to the left and the right side contained crates with gallons of milk and juice. KC stated that they received the delivery of those items at 10:00 AM. | F 812 | Dietary Walk In Refrigeration<br>1. Delivery was immediately put away by kitchen staff after observation was made on 9/19/2023.<br>2. All persons eating food prepared by the hospital do have the potential to be affected by this deficient practice if proper food and non-food storage procedures are not followed.<br>3a. Kitchen Manager provided re-education to staff on proper food and non-food items storage procedures per Food Service Safety Professional Standards with emphasis that the floor is considered dirty and that no food items can be placed on the floor.<br>3b. The delivery personnel were provided verbal education the following week that included: delivered items cannot be placed on the floor, they must be placed at least 6 inches off the floor, and going | |

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| F 812 | Continued From page 9<br>On 09/19/23 at 10:45 AM, conducted a concurrent observation and interview with the Director of Food Services (DFS) of the same chiller. DFS stated that the delivery personnel will alert staff that the items were placed into the chiller. DFS further confirmed that the kitchen staff should have put the items away on the shelves of the cart right away as the items should be stored at least 6 inches off the ground.<br><br>Record review of policy and procedure from the Department of Nutritional Services on Infection Control, "Policy No.: 140-300-1" with effective date 02/17/21. It stated, " ... III. PROCEDURE: ... 6. Food must be stored at least eighteen (18) inches above the floor ..."<br><br>2) On 09/19/23 at 11:48 AM, conducted initial lunch observations. Dietary Aide (DA)1 delivered a lunch tray to resident (R)12 in R12's room. DA1 moved items on R12's tray and touched the bedside table while conversing with R12. DA1 exited the room without taking off his gloves and performing hand hygiene. DA1 proceeded to deliver the rest of the lunch trays to residents in the day room and residents in their rooms.<br><br>On 09/20/23 at 12:05 PM, conducted follow up observations of lunch tray deliveries. DA2 wore gloves when delivering a tray to a resident in the day room. DA2 was back at the meal tray delivery cart when his cell phone rang in his pants pocket. DA2 proceeded to take out his cell phone from his pocket, looked at it, and then put it back into his pants pocket. DA2 did not remove his gloves and hand hygiene before taking out another lunch tray to deliver.<br><br>On 09/22/23 at 09:13 AM, interviewed the | F 812 | forward all delivered items must be placed on the extra crates in the cooler. This process will comply with keeping food items off the floor, if there is no staff to immediately receive the deliveries.<br>3c. All new Nutritional Service staff will receive education on proper food and non-food items storage procedures during unit orientation.<br>4a. The opening manager will monitor and log all walk in refrigeration deliveries to observe for compliance. Observations will be tracked on a Delivery Log maintained by the opening manager.<br>4b. Executive Sous Chef or designee will report findings from the Delivery Log monthly monitoring to HPIC for three consecutive bi-monthly meetings and/or until 100% compliance is achieved.<br>Meal Tray Delivery<br>1. Kitchen Manager provided re-education to the food service staff concerning hand hygiene upon learning of the deficient practice during the survey. Staff were also re-educated on cell phone policy use during work hours.<br>2. All residents do have the potential to be affected by this deficient practice.<br>3a. Ongoing hand hygiene refresher education will be done monthly.<br>3b. Spot checks on tray deliveries will be conducted by kitchen manager to validate ongoing hand hygiene compliance. Regional Director of Nutrition Food Service will assist with random hand hygiene audits when on site.<br>4. Regional Director of Nutrition Food Service will provide a report of findings from hand hygiene audits to HPIC for | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125021 | A. BUILDING _____ B. WING _____ | 09/22/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KAUAI VETERANS MEMORIAL HOSPITAL | 4643 WAIMEA CANYON DRIVE WAIMEA, HI 96796 |

| (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) COMPLETION DATE |
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| F 812 | Continued From page 10<br>Infection Preventionist (IP) in the conference room, IP was notified of lunch tray deliveries by DA1 and DA2. IP stated she expects glove removal, hand hygiene, and new gloves donned to have occurred after DA1 touched the items on R12's tray and bedside table before delivering the rest of the lunch trays. IP also stated that DA2 should have also removed his gloves, performed hand hygiene, and donned on a clean pair of gloves after placing his cell phone back into his pants pocket. IP stated that she has not done any hand hygiene audits of the kitchen staff.<br><br>Record review of policy and procedure from the Department of Nutritional Services for Personal Hygiene, effective date 02/23/21, "Policy No.: 140-400-5." It stated, " ... HAND WASHING ... 3. Wash hands frequently, including after ... the use of cellular phones ..." | F 812 | three consecutive bi-monthly meetings and/or until 100% compliance met. | |