STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 000	INITIAL COMMENTS The Department of Health, Office of Health Care Assurance, conducted a recertification survey on 10/24/23-10/30/23. The facility was found not be in compliance with 42 CFR §483, Subpart B. The Office of Health Care Assurance will accept the federal Medicare recertification of this facility for state relicensing purposes and has exempted this facility from a relicensing inspection as authorized by Chapter 11-94.2, Hawaii Administrative Rules, §11-94.2-6(e). Refer to the federal Medicare recertification survey report to review the statement of deficiencies and the facility's plan of correction. Past noncompliance was also identified and cited for F689, Free of Accident Hazards/supervision/devices. The census was 43 residents at the time of entrance.	F 000		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with	F 625		12/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/11/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 625	Continued From page 1	F 625		

paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review (RR) and interview, the facility did not provide a written notice to specify a bed-hold at the time of transfer. In addition, the facility failed to provide written information to the resident and/or resident representative at the time of transfer.

Findings include:

RR of resident (R)37 reveals multiple hospitalizations to an acute facility. R37 was initially admitted to the facility on 09/13/2022. Most recent admission was 10/27/23 at 11:46 AM. Unable to locate via record review documentation regarding bed-hold policy except on admission and notice of transfer to resident or resident representative.

Interview with Nursing Home Administrator (NHA) and Direction of Nursing (DON) regarding admission to the hospital for R(37). He was admitted on 09/30/23 for aspiration and then most recently on 10/27/23. NHA stated that they have a weekly communication every week and the facility still has a bed for him. NHA stated that

F 625 Notice of Bed Hold Policy Before/Upon Transfer SS: D

IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN.

All residents have the potential to be affected by this deficiency.

The facility will follow the East Hawaii Region Long Term Care Bed Hold policy. Copies of the Bed Hold form have been added to the facility transfer packet.

MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE

All licensed nurses will be educated and trained on the EHR Long Term Care Bed Hold policy and Bed Hold Information form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 625	Continued From page 2 they have no written communication that goes out to patient representative before transfer. On further questioning, it was revealed that the facility provides a notice of bed-hold transfer by admission agreement on admission; however, not at the time of transfer for hospitalization.	F 625	MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS The Director of Nursing/Designee will complete weekly audits of all residents that have been discharged or transferred from Long Term Care x 90 days or until 100% compliance is met to monitor the effectiveness of these changes and ensure that correction is achieved and sustained. The results of these audits will be reported at QAPI.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review (RR), two residents of the three sampled resident (R)38 and R43, failed to receive accurate assessments, reflective of their status at the time, to identify relevant care areas. As a result of this deficiency, their care plans (CP) did not identify focus areas needed to ensure they maintain or attain their highest medical, functional, and psychosocial potential. All residents are at risk of not receiving an accurate assessment. Findings include: 1) On 10/27/2023 at 08:00 AM, observed R38 in his room, lying in bed. During the interview, he said he had a "cracked tooth, for some time." R38 said he wanted to have the tooth taken out. The MDS (Minimum Data Set), used for standardized	F 641	F 641 Accuracy of Assessments SS: D Corrective action of resident identified R38 MDS assessment corrected and revised on 12/05/23 to reflect obvious or likely cavity or broken natural teeth in MDS Dental Section L. R43 MDS corrected and revised with check mark for MDS Dialysis in Section O (special treatments, Procedures) on 10/24/23. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN.	12/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE

F 641

Continued From page 3

assessments (comprehensive, quarterly, significant change in status) includes a "Dental Section L." which assesses for any "Obvious or likely cavity or broken natural teeth." On R38's annual assessment completed on 02/07/2023, this was checked off, indicating he did have a current issue with his natural teeth. On 08/12/2023, R38 was transferred to the hospital for altered mental status and respiratory failure. When he was discharged, R38 returned back to the facility. An "Entry tracking record" was created on 08/19/2023, which indicated "add new record." This assessment did not identify or document R38 had the ongoing dental issue, and therefore did not trigger or activate a care plan for a dental focus, goal, or interventions.

On 10/27/23 at 09:13 AM, interviewed MDS Coordinator (MDS)1, who completed R38's assessments. At that time, she reviewed the documentation, and acknowledged the assessment completed on his return to the facility was not accurate, and should have documented the dental issue.

2) R43 is a 77-year-old resident admitted on 02/02/23 for long-term care. Diagnoses include end stage renal disease and dependence on renal dialysis. Review of R43's Electronic Health Record (EHR) revealed two quarterly MDS (Minimum Data Set) assessments were done with an assessment reference date of 08/04/23. Under Section O, Special Treatments, Procedures, and Programs, there was no check mark if dialysis was performed in the last 14 days for one of the MDS assessments.

On 10/24/23 at 01:30 PM, an interview with R43 was conducted in his room. R43 said he has been on dialysis for the past 22 year and has

F 641

All residents have the potential to be affected by this deficiency.

An audit of sections L and O of all MDS submitted within the last 90 days will be reviewed for accuracy of assessments.

MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE

MDS Nursing will be educated on State Operations Manual Appendix PP Guidance to Surveyors for Long Term Care Facilities (Rev. 211, 02-03-23) F641 483.20 (g) Accuracy of Assessments.

MDS Nursing will be educated on CMS RAI Version 3.0 Manual Sections: L and O

Sections L and O will be reviewed by a member of the RAI department prior to submission to ensure accuracy of coding reflective of residents status at the time of the assessment to identify relevant care areas.

MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS

MDS Assessments sections L and O will be reviewed weekly x 90 days to ensure accuracy of the assessment and that it reflects the status of the residents at the time of the assessment, to identify relevant care areas are care planned to ensure they maintain or attain their highest medical, functional, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 641	Continued From page 4 treatments three times a week. On 10/26/23 at 01:43 PM, concurrent interview and record review conducted with MDS Coordinator (MDS) 2. Review of the "MDS" tab of the EHR showed two quarterly assessments dated 08/04/23. Under the "Status", one had "Modified" and the other had "Export Ready". MDS2 confirmed that the first quarterly MDS completed on 08/04/23 that had "Modified" under the status was not accurate because there was no check mark for "Dialysis" in Section O. MDS2 said the information was updated on 10/24/23 when they realized the "MDS Resident Matrix" that they ran after the entrance conference was incorrect.	F 641	psychosocial potential. Findings of the weekly MDS assessment reviews sections L and O will be submitted to QAPI to monitor the effectiveness of these changes and to ensure correction is achieved and maintained.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		12/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 656	Continued From page 5 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement person-centered comprehensive care plan for one of two sampled residents (Resident (R) 39). An intervention to prevent falls for R39 was not implemented. As a result of this deficient practice, the R39 was placed at risk for potential harm from avoidable falls and has the potential to affect all resident at the facility on close monitoring. Findings include:	F 656	F 656 Develop/Implement Comprehensive Care Plan SS: D Corrective action of resident identified R39 1:1 Monitor/Q15 minute monitoring sheet revised to include license signature to verify completion of interventions implemented to prevent avoidable falls. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE

F 656

Continued From page 6

On 10/24/23 at 11:37 AM, observed R39 lying in bed, awake, with Certified Nurse Assistant (CNA) 11 sitting at bedside. CNA11 said R39 is on one-on-one close observation during the day due to a history of frequent falls.

Review of R39's care plan documented that he is at risk for falls and interventions included but not limited to, "1:1 (one-on-one) observation and supervision, Q-15 (every 15) minute check QHS (every night at bedtime)." Further review of progress notes for the past six months revealed R39 has had falls on the following dates: 04/03/23, 04/15/23, 04/25/23, 05/19/23, 05/30/23, 05/31/23, 06/06/23, 06/13/23, and 06/14/23. One-on-one observation was implemented on 06/15/23 after the interdisciplinary team meeting.

On 10/27/23 at 08:03 AM, interview with Registered Nurse (RN) 5 was conducted at the nurses' station. RN5 said that a CNA is always assigned to stay with R39 while he is awake and at night whenR39 is sleeping, the staff check on him every 15 minutes. RN5 added that the staff document the 15-minute checks on a log but was not able to locate them when asked. Monitoring logs for October were later provided by the Administrator at 11:30 AM. Review of the logs revealed that there were multiple instances where there were no entries every 15 minutes when R39 was sleeping as specified in the care plan intervention.

On 10/30/23 at 12:40 PM, interview conducted with Administrator in her office. Administrator confirmed that since the intervention in the care plan stated to check on the R39 every 15 minutes, the expectation is for the staff to record an entry into the log every 15 mins when

F 656

AND WHAT CORRECTIVE ACTION WILL BE TAKEN.

All residents that are placed on frequent monitoring have the potential to be affected by this deficiency.

An audit was completed and there are no other residents on q15 minute checks at this time.

MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE

All Nursing staff educated and in-serviced on the revised 1:1 Monitor/Q15 minute monitoring sheet.

All Nursing staff educated on 483.21 Comprehensive Person-Centered Care Planning.

License Nurse/Designee will review 1:1 Monitor/Q15 minute monitoring sheet at the end of each shift to ensure entries are recorded as specified according to the time frame on the monitoring sheets.

MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS

1:1 Monitor/Q15 minute monitoring sheets will be reviewed weekly by the Director of Nursing and/or designee x 90 days to ensure entries are recorded as specified according to time frame on monitoring sheets.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 656	Continued From page 7 one-on-one observation is not being provided. No entries were being recorded.	F 656	Findings of the 1:1 Monitor/Q15 minute monitoring sheets will be submitted to QAPI to monitor the effectiveness of these changes and to ensure correction is achieved and maintained.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 657	F 657 Care Plan Timing and Revision SS:	12/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE

F 657

Continued From page 8

review, the facility failed to meet the standards of good clinical practice and ensure timeliness of revisions to the Care Plan (CP) of two Residents (R) of a sample size of 3, R9 and R43. Specifically, R9's dental issue, was not addressed in his CP and R43's hearing aid was not being used.
As a result of these deficiencies there was the potential they would not meet their highest level of medical, physical and psychological well-being. This deficient has the potential to affect all residents.

Findings include:

1) R9 was admitted to the facility on 08/05/2022, and is a long term resident. His medical history includes, type 2 diabetes, hypertension, Parkinson's disease, dementia without disturbance, major depressive disorder, and acute kidney failure.

On 10/27/2023 at approximately 08:30 AM, during an interview with R9 in his room, he said he had been having tooth pain, and pointed to the upper tooth. He went on to say, he wanted it removed because he had a bad experience with another tooth and didn' t want to get an infection.

Review of R9's nursing progress included, but not limited to the following entries:
10/27/2023 at 01:47 AM: "No c/o (complaint of) any discomfort to left upper tooth ..."
10/26/2023 at 06:30 PM: "Resident w/out (without) c/o tooth pain. ..."
10/26/2023 at 03:19 PM: "No c/o left upper tooth pain throughout this shift. ..."
10/26/2023 at 06:23 AM: "Denies tooth pain. ..."
10/25/2023 at 11:07 PM: "Denies tooth pain. ..."

F 657

D

Corrective action of resident identified

R9□s care plan was revised on 10/27/23 to include dental focus problem with goal and interventions.

R43□s care plan was revised on 10/30/23 to include hearing aids were being replaced for sizing.

IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN.

All residents have the potential to be affected by this deficiency.

MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE

All Nursing staff educated on State Operations Manual Appendix PP □ Guidance to Surveyors for Long Term Care Facilities 483.21 (b) (2); F657 to ensure the timeliness of each resident□s person-centered, comprehensive care plan are reviewed and revised by IDT

24-hour report will be reviewed daily in clinical meeting and care plans will be revised and updated as necessary.

MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 657	Continued From page 9 10/25/2023 at 03:51 PM: "No c/o left upper tooth pain." 10/25/2023 at 03:45 AM: "No c/o tooth pain. ..." 10/24/2023 at 09:50 PM: "...Denies tooth pain." 10/24/2023 at 03:11 PM: "Continues on alert for left upper tooth pain. ..." 10/24/2023 at 05:40 AM: "resident is on alert for left upper tooth pain. ..." 10/23/2023 at 09:14 PM: "On alert for upper tooth pain. ..." Review of IDT (interdisciplinary team) note by Dietician revealed the following entry: 10/23/2023 at 04:16 PM: "Met with resident regarding teeth pain. ..." Review of R9's active CP revealed "Dental," was not included as a focused problem with a goal and interventions. On 10/272023 at approximately 01:30 PM, the facility provided a revised CP to include "Dental." 2) R43 was admitted to the facility on 02/02/23 for long-term care. Interview conducted with R43 in his room on 10/24/23 at 01:39 PM. Prior to the interview, observed R43 watching television with the volume on high. R43 stated that he is hard of hearing and that he has a hearing aid but was not using it. When asked why he was not using the hearing aid, R43 said he is not able to place it in his ears by himself because the device was small, and he has poor dexterity. R43 also added that he did not know where it is now since he has not used it for some time. Review of Electronic Health Record (EHR) conducted. R43's active care plan dated 06/15/23 stated he has a communication problem related to his impaired hearing. The only intervention documented in the care plan was to ensure hearing aid to both ears are in place.	F 657	24-hour report audit tool to be reviewed weekly by Director of Nursing and/or designee x 90 days to ensure timeliness of each resident□s person-centered comprehensive care plan and that the care plan is reviewed and revised by the IDT. Findings of the 24-hour report audit tool will be submitted to QAPI to monitor the effectiveness of these changes and to ensure correction is achieved and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 657	Continued From page 10 On 10/30/23 at 10:21 AM, concurrent interview and record review conducted with Licensed Practical Nurse (LPN) 2 at the nurses' station. Asked LPN2 why R43's hearing aid was not being used. LPN2 replied she was not aware that he had a hearing aid. LPN2 reviewed active care plan in the EHR and confirmed intervention to ensure R43 used hearing aid for both ears. LPN2 said she will follow up with R43's family representative. At 11:34 AM, LPN2 said she called R42's family representative and was told they were waiting for a replacement device since the old one was too small. LPN2 confirmed that the active care plan intervention was not updated with she will correct it before the end of her shift.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interviews, observation and record review, the facility failed to provide consistent repositioning for one of the one sampled	F 686	F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer SS: D	12/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE

F 686

Continued From page 11

residents (R) 45 in the sample. R45 had an existing Stage 4 (Full-thickness skin and tissue loss) Pressure Ulcer (PU) on the sacrum. As a result of this deficiency, R45 was at increased risk for new PU's and the potential of healing the current PU was decreased. This deficient practice could affect any resident identified at risk for the development of PU, and those with current PU's, resulting in preventing them from reaching their highest physical and psychosocial well-being.

as ordered, and consistent with professional standards of practice.

Findings include:

R45 is a 65 year old male admitted to the facility on 03/07/2023. He has a pertinent medical history that includes a history of paraplegia (paralysis, loss of function in the lower part of body) due to astrocytoma (tumor of the spinal cord) with a neurogenic bladder (lack of control of bladder). He has a chronic indwelling Foley catheter, and being treated for wound management of a Stage 4 PU of the sacrum. R45 is not mobile and stays in bed. He requires assistance to reposition. R45 was hospitalized from 08/01/2023-08/22/2023 due to Urinary Tract Infection and diagnosed with sepsis. When discharged, he returned to the facility for ongoing long term care.

1) On 10/27/2023 at 08:38 AM, observed R45 lying on his back, During an interview at that time, asked him how often the staff repositioned him to promote healing of the sacrum PU. R45 said, "About every couple of hours." R45 went on to say the Physical Therapist (PT) wanted him to be at 45 degrees on his side, but he did not like that.

F 686

Corrective action of resident identified

R45 task list for repositioning revised to Q1HR to ensure resident has the potential of healing pressure ulcer and reaching their highest physical and psychosocial well-being.

IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN.

All residents have the potential to be affected by this deficiency.

Facility wide audit completed to identify residents at high risk for skin breakdown and those with current pressure ulcers.

MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE

All Nursing staff educated on Lippincott�s Textbook for Nursing Assistant�s � Repositioning a Person and documenting accordingly, avoiding gaps and including resident refusals.

Repositioning Focus Round has been developed and will be completed weekly x 90 days by Director of Nursing and/or designee for residents at high risk for skin breakdown and those with current pressure ulcers.

MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 686	Continued From page 12	F 686		

On 10/27/2023, at 10:25 AM, during an Interview with Certified Nurse Assistant (CNA)10, asked her about R45's mobility and positioning. She said he was totally dependent on staff to reposition, and "He is suppose to be turned every hour."

On 10/27/23 at 10:30 AM, accompanied the RN to observe a dressing change of R45's sacrum wound. At that time, noted him to be in the same position on his back. When the RN prepared R45 for the dressing change, observed there was a wedge on his right side located by his waist, providing some offloading to the wound. When the RN completed the dressing change, R45 was very specific and told the RN where to place the wedge. Inquired if he ever rotated more on his side to look out the window, and the RN said he refuses.

On 10/27/2023, at 01:00 PM, Physical Therapy (PT)1 accompanied surveyor to assess R45's positioning. At this time he was in the same position on his back, the same position when the dressing change occurred at 10:30 AM. PT1 said she would like R45 be more at 45 degree angle, but due to his neuropathic pain in his back, thorax and shoulders, he is unable to do so. She said he does not like to face toward the window. PT demonstrated the wedge was offloading pressure on his wound, by placing her hand under him.

Reviewed R45's care plan history, which revealed the following entries:
On 03/04/2023, the CP included: "The resident needs assistance to turn/reposition at least every 2 hours and more often as needed or requested."
On 09/08/2023, the CP was revised to include "Ensure frequent small turns with repositioning of

Findings of the Repositioning focus rounds will be submitted to QAPI to monitor the effectiveness of these changes and to ensure correction is achieved and maintained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 686	Continued From page 13	F 686		

sacrum to prevent further pressure."
On 10/11/2023, the CP was revised to include "Ensure frequent small turns with repositioning off of sacrum to prevent further pressure. Offer every hour and with rounding."

The current, active CP included, but not limited to the following:
Focus: "The resident has a stage 4 pressure injury to sacrum and history of non-compliance with turning and positioning (10/10/2023)."
Interventions/Tasks included: "...4. Place one wedge at buttocks, 2 wedges at shoulder blades. ..."

Reviewed the "Follow up Question Report" for October 2023, which summarized the Certified Nurse Assistants documentation of task completion for the question "Did you turn and reposition every hour. Ensure resident is not [sic] positioned off of his sacrum to prevent further pressure to wound. The report included, but not limited to the following gaps of time when R45 was not repositioned, or documented a refusal to do so:
10/16/2023: Repositioned at 03:07 PM, next documented at 06:22 PM.
10/17/2023: Repositioned at 01:30 AM, next documented at 05:53 AM.
10/18/2023: Repositioned at 02:36 AM, next documented at 05:51 AM.
10/19/2023: Repositioned at 05:16 AM, next documented at 11:25 AM.
10/19/2023: Repositioned at 01:00 PM, next documented at 06:58 PM.
10/20/2023: Repositioned at 04:00 AM, next documented at 08:12 AM.
10/20/2023: Repositioned at 02:50 PM, next documented at 07:57 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE

F 686 | F 686

Continued From page 14

10/21/2023: Repositioned at 01:57 PM, next documented at 06:56 PM.
10/24/2023: Repositioned at 01:11 AM, next documented at 05:17 PM.
10/24/2023: Repositioned at 01:00 PM, next documented at 08:28 PM.

Reviewed the facility policy titled "Quality of Care Skin Integrity," dated 05/2023. The policy guidelines included:
"6. A resident identified as at risk of developing PU/PI's (pressure injuries) will have individualized interventions implemented to attempt to prevent PU/PI from developing. ..."
"15. Prevention and treatment plans will be individualized and consistently provided."
"18. If a resident is refusing care and treatment, the facility will attempt to identify the basis for the refusal and identify potential alternatives, as indicated."
"22. Repositioning or relieving constant pressure is an effective intervention for treatment or prevention of PU/PIs. ..."

F 689 SS=G | F 689

Free of Accident Hazards/Supervision/Devices
CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure one of the residents

Past noncompliance: no plan of correction required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 689	Continued From page 15 (Resident (R) 161) in the sample was free from accident hazards from the use of a mechanical lift. A facility staff independently operated the mechanical lift without assistance form another staff member. As a result of this deficient practice, R161 sustained multiple fractures to his vertebra and ribs. This deficient practice has the potential to affect all residents that require the use of a mechanical lift for transfers. Findings include: Review conducted for the Facility Reported Incident (FRI) document retrieved from Aspen Complaints/Incidents Tracking System (ACTS) 10397. Initial report was submitted to the Office of Healthcare Assurance on 06/29/23 and the completed report on 07/07/23. Type of incident was listed as "Other, Serious Bodily Injury." Details of incident stated that on 06/29/23, R161 was being transferred from the wheelchair to the bed using a mechanical lift by a Certified Nurse Assistant (CNA) when the lift malfunctioned and R161 fell to the floor from an approximated height of three feet. R161 was transferred to a local acute care hospital and subsequently admitted for multiple acute fractures of his spine and ribs. The CNA was immediately placed on administrative leave until the investigation was completed. The mechanical lift was removed from service and inspected by maintenance team on 06/29/23. A facility-wide inspection of all mechanical lifts was completed on the same day. It was identified that the lifting strap failed and all other were confirmed to be functioning properly. Maintenance inspections were being completed monthly with the last one done on 06/14/23. On 07/06/23, maintenance and inspections were	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 689	Continued From page 16 transitioned to a different team and completed per manufacturer guidelines. The CNA that transferred the resident confirmed that she was operating the mechanical lift without the assistance of another staff member. On 06/30/23, all staff were required to watch a training video on the proper use of the mechanical lift. Education was also provided on the facility policy where two staff members must always be present for all resident transfers using the mechanical lift. Skills validation training was also conducted and documented. The training and skills validation was made mandatory for all employees and was completed on 07/27/23. All new employees hired after the incident were also required to complete the mechanical lift training and skills validation. After completion of the mandatory training, the facility developed focused rounds to monitor compliance of the staff when using the mechanical lifts. Findings were reported in the Quality Assurance and Performance Improvement (QAPI) meetings monthly for 90 days. On 10/27/23 at 09:44 AM, interview conducted with Restorative Aide (RA) 2 in the hallway of Koa Lane unit. RA2 verbalized that two staff members are required when using the mechanical lift and safety checks need to be completed prior to its use.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		12/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 759	Continued From page 17	F 759		

§483.45(f)(1) Medication error rates are not 5 percent or greater;
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that the medication error rate was less than 5 percent for one of five sample residents Resident (R)46. This deficient practice has the potential to harm other residents and failure for R46 to reach their highest practicable level of health and well-being.

Findings include:

Observation and concurrent record review (RR) on 10/26/23 at 08:36 PM was done during medication pass with Registered Nurse (RN)4. Doctor's orders for Metoprolol 100 mg extended release (ER) to give one tab twice a day for hypertension. RN4 reported blood pressure was 96/64 mmHg and stated that she was going to hold the medication from the resident. Surveyor asked if there were parameters to hold the medications and RN4 stated there were no parameters. Surveyor asked if this was a common practice of other nurses for this blood pressure reading. RN4 stated "I am not responsible for what others do."

RN4 stated that she was going to hold blood pressure medication Lisinopril/hydrochlorathiazide 50 mg which is given one tablet by mouth every day. This medication also did not have parameters written by the physician to follow. RN4 further stated that all of R46's medications are crushed. R46 receives Metoprolol 100 mg extended release (ER) which is against advisement of

F 759 Free of Medication Error Rts 5% or more SS: D

Corrective action of resident identified

R46 Lisinopril/hydrochlorothiazide 50 mg order revised on 10/26/23 to include BP parameters.

R46 Metoprolol ER was discontinued on 11/02/23.

IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN.

All residents have the potential to be affected by this deficiency.

Physicians were contacted for all residents with antihypertensives so they could determine if they wanted to add parameters to any of the orders.

Facility wide audit completed to identify residents that require their medications to be crushed to ensure medications ordered are not included on the Pharmerica DO NOT crush medication list.

MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 759	Continued From page 18 manufacturer recommendations to crush time-released medications and in this case Metoprolol is an extended release.	F 759	License nurses educated on Communicate with MD/Provider regarding parameters and if no parameters, DO NOT hold without MD order. License nurses educated on Do Not Crush Extended-Release medications. License nurses provided with Pharmerica Do Not Crush medications list and DO NOT CRUSH medication list placed on each med cart. License nurses educated Communicate with PharmD and Providers for recommendations accordingly; possible change in medication/form Medication Administration hold audit report will be reviewed daily in clinical meeting. Director of Nursing and/or designee will complete Medication Administration Observation tool weekly to ensure proper administration x 90 days. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS Medication Administration audit hold report will be reviewed weekly by the Director of Nursing and/or designee x 90 days to ensure held medications were communicated prior to being held and/or confirm parameters. Medication Administration Observation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 759	Continued From page 19	F 759	tool be reviewed weekly by the Director of Nursing and/or designee x 90 days to ensure residents that require their medications to be crushed are not included on the DO NOT crush list. Findings of the Medication Administration hold audit report and the Medication Administration Observation tool will be submitted to QAPI to monitor the effectiveness of these changes and to ensure correction is achieved and maintained.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		12/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 761	Continued From page 20 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure appropriate temperatures for one of its two medication refrigerators that are monitored and maintained. This deficient practice has the potential to negatively affect the efficacy and integrity of medications that require storage at proper temperatures. Findings include: On 10/26/23 at 03:27 PM, observation and concurrent interview of the medication refrigerator was done with Registered Nurse (RN) 6 on the first-floor unit. The refrigerator contained insulin, suppositories and vaccines. Further review of the instructions on the temperature log stated, "Refrigerator temperature to be monitored and documented on day shift and NOC [night] shift to maintain a desired refrigerator temperature of 36-46 degrees Fahrenheit (F)." Temperature log for the month of October was on the door of the refrigerator. Review of the log showed that the temperature readings for 10/18/23 was missing. RN6 confirmed that the nurses assigned to work on that day should have checked and documented the temperatures on the log.	F 761	F 761 Label/Store Drugs & Biologicals SS: D IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN. All residents have the potential to be affected by this deficiency. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE License Nurses educated on Medication Refrigerator Temperature-to ensure integrity/efficacy of vaccines etc.&being stored Unit Manager task list developed to include monitoring of Medication Refrigerator Temperature log. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS Medication Refrigerator Temperature logs will be reviewed weekly x 90 days by Director of Nursing and/or designee to ensure the efficacy and integrity of medications that require storage at proper temperatures.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 761	Continued From page 21	F 761	Findings of the Medication Refrigerator Temperature logs will be submitted to QAPI to monitor the effectiveness of these changes and to ensure correction is achieved and maintained.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure dishes used to serve food were appropriately sanitized in accordance with professional standards for food service safety. This deficient practice placed all the residents in the facility at risk for possible foodborne illnesses. Findings include:	F 812	F 812 Food Procurement, Store/Prep/Serve-Sanitary SS: D IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN. All residents have the potential to be	12/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE

F 812

Continued From page 22

An observation and concurrent interview was done on 10/24/23 at 09:47 AM. The initial tour of the kitchen area was conducted with Dining Services Director (DSD). Observed a log on the wall by the dishwashing machine that DSD identified as the temperature log. DSD added that the staff use the log to record the temperatures for the dishwasher to make sure that the dishes are disinfected properly after use.

Review of the log titled "Dishwashing/Warewashing Machine Temperature Log" and noted an entry for 10/23/23 was missing. Asked DSD how often the staff record the temperatures on the log. DSD said the staff record it three times a day since they use the dishwashing machine after each meal service. Asked DSD if the dishwasher was used after dinner on 10/23/23. DSD looked at the log and said "Yes, but they forgot to record the temperature in the log." DSD apologized and said he will remind the staff the importance of recording the temperatures on the log since it can affect all the residents if the dishes were not disinfected properly.

F 812

affected by this deficiency.

MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE

All Dietary staff educated on State Operations Manual Appendix PP Guidance to Surveyors for Long Term Care Facilities 483.60 (i); Food Safety Requirements

All Dietary staff educated on proper documentation frequency (breakfast, lunch, dinner) for Dishwashing/Warewashing Machine Temperature Log.

Dishwashing/Warewashing Machine Temperature Log monitoring added to the Dietary Supervisor daily task list.

MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS

Dishwashing/Warewashing Machine Temperature Log will be reviewed weekly x 90 days by Dining Services Director and/or designee to ensure proper sanitization in accordance with professional standards for food service safety.

Findings of the Dishwashing/Warewashing Machine Temperature Log will be submitted to QAPI to monitor the effectiveness of these changes and to ensure correction is achieved and maintained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		12/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 880	Continued From page 24 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure shared medical devices were properly disinfected after use. Specifically, the facility did not use the appropriate disinfectant to wipe the shared blood glucose meter (device used to measure blood sugar levels). The facility also failed to ensure proper hand hygiene was used to prevent the transmission of commumnicable diseases and infections. The deficient practice have the potential to spread communicable diseases and	F 880	F 880 Infection Prevention & Control SS: D Corrective action RN6 and RN5 educated on the proper process for disinfecting glucometers. Signage created Use Bleach wipes only for glucometer placed on medication carts.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ____ B. WING ____	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE

F 880

Continued From page 25

infections to other residents that use the same device to have their blood sugar levels checked.

Findings include:

1) On 10/26/23 at 03:27 PM, observation and review of the medication cart was conducted with Registered Nurse (RN) 6. Observed a blood glucose meter in the top drawer of the cart that RN6 said the staff use to check blood sugar levels of multiple residents on the unit. Asked RN6 how often is the device disinfected. RN6 replied the staff disinfect it immediately after each use with alcohol wipes. When asked why the staff use alcohol wipes, RN6 said, "The other wipes make the meter break easily."

On 10/27/23 at 10:19 AM, interview conducted with RN5 at the nurses' station. Asked RN5 what the staff use to disinfect the shared blood glucose meter. RN5 replied, "We use the PDI Sani Cloth that is on the other cart but sometimes just use the alcohol pads because the other one (PDI Sani Cloth) breaks the meter and even the iPads."

Review of the "Users' Guide" for the blood glucose meter (EvenCare G2 Meter) used by the facility revealed that alcohol wipes or pads was not on the list of products the manufacturer validated for disinfecting the meter.

CMS (Centers for Medicare and Medicaid Services) Memo, S&C: 10-18-NH dated 08/27/10 stated, ". . . Point of care devices, such as blood glucose meters, . . . if used for multiple residents, must be cleaned and disinfected after each use according to manufacturer's instructions. . ."

2) Observation was done on 10/24/23 at 12:02

F 880

IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN.

All residents have the potential to be affected by this deficiency.

MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE

All License Nurses educated on Avoid and Prevent Transmission of Bloodborne Pathogens; ensure Glucometers are disinfected using bleach in between residents and after each use

All staff educated on Prevent the spread of infection; perform hand hygiene: prior to handling medications and after administration, between tasks and glove use, between passing of meal trays

Infection Control Observations focus round developed to ensure compliance with proper hand hygiene and medical devices (Glucometer) are properly disinfected after use.

MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS

Infection Control Observations focus round will be reviewed weekly x 90 days by the Infection Control Officer and/or designee to ensure a safe, sanitary and comfortable environment and to help

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE 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) COMPLETION DATE
F 880	Continued From page 26 PM of lunch delivery. The lunch cart was parked at room 208. Clinical nurses assistant (CNA)12 was observed to grab tray and enter room with tray without hand sanitizing or hand washing. CNA12 was noted to hand sanitize on the way out of the room. CNA12 then entered room 210. Upon entrance to Room 210, no HS was done on the way in. CNA was noted to open cart doors, open door to room before serving the tray. CNA 10 was in the hall with CNA12 at rom 207. CNA10 did not HS on the way in and HS only on the way out. This process was repeated with 209 with CNA 10. Interview was done on 10/24/23 at 12:14 with CNA 10. Surveyor queried regarding their policy for passing trays during lunch delivery. CNA 10 stated that we hand sanitize on the way in and we do three trays and then wash our hands. We sanitize every tray coming out. Record review (RR) of the policy dated 06/2023 titled Infection prevention and control program under (III) Procedure for Standard Precautions reads: a. (i) Avoid unnecessary touching of surfaces in close proximity to the resident when providing care. (iv) Before having direct contact with a resident with suspected or confirmed infections.	F 880	prevent the development and transmission of communicable diseases and infections. Findings of the Infection Control Observations focus reviews will submitted to QAPI to monitor the effectiveness of these changes and to ensure correction is achieved and maintained.	