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	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kauai Veterans Memorial Hospital	4643 Waimea Canyon Drive Waimea, HI 96796

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on record review and interview the facility failed to identify and report, within 14 days, a significant change and decline in activities of daily living (ADLs) for 1 of 12 residents sampled (Resident (R) 11). This deficient practice has the potential to affect other residents who have a decline in health status. Findings include: On 09/05/24 record review of R11's Electronic Health Record (EHR) Minimum Data Set (MDS) Annual assessment dated [DATE] and Quarterly review dated 04/26/24 revealed she had the following declines in functional limitations: limitations progressing from one lower extremity to two lower extremities, now requires substantial/maximal assistance with upper body dressing when she was previously partial/moderate assistance, and went from being able to roll left and right with partial/moderate assistance to roll left and right requiring substantial/maximal assistance. Review of R11's MDS assessments submitted to the Centers for Medicare and Medicaid Services (CMS) revealed no Significant Change in Status assessments. On 09/06/24 at 09:43 AM, interviewed the Minimum Data Set Coordinator (MDSC) and inquired if R11 had a significant change with her ADLS requiring more assistance with care. R11's MDS assessments submitted on 01/28/24, 04/26/24, and 07/21/24, were reviewed by MDSC who confirmed R11 did have a significant change with her ADLS that was identified and should have been reported to CMS .

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.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on record review and interview the facility failed to accurately document the health status of two residents reviewed, Residents (R)20 and 11. R20 was incorrectly identified as taking insulin for one day and R11 was incorrectly identified as having a diagnosis of Alzheimer's Disease when she has a diagnosis of severe vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance or anxiety. This deficient practice has the potential to affect all the residents at the facility if their health status is not correctly identified. Findings include: 1) On 09/05/24 record review of R20's Electronic Health Record (EHR) revealed R20's Minimum Data Set (MDS) Admission assessment dated [DATE] identified her taking insulin for 1 day. Review of R20's EHR medication orders did not find any insulin orders. On 09/06/24 at 09:33 AM, interviewed Minimum Data Set Coordinator (MDSC) who confirmed resident does not take insulin and confirmed this was an error. MDSC believes it might have been a different injection she received such as an immunization. 2) On 09/06/24 record review of R11's EHR revealed she had a diagnosis of severe vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance or anxiety. Review of R11's Minimum Data Set Quarterly review dated 07/21/24 found R11 had Alzheimer's Disease checked off. On 09/06/24 at 09:33 AM, interviewed Minimum Data Set Coordinator (MDSC). MDSC reviewed R11's MDS Quarterly review dated 07/21/24 and saw R11 had the Alzheimer's Disease box checked. MDSC stated this was an error on the resident's MDS and confirmed that R11 does not have an Alzheimer's Disease diagnosis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on interview and record review, the facility failed to develop and/or implement a resident-centered Comprehensive Care Plan (CP) for 2 of 13 residents (Residents 5 and 1) in the sample. Both residents (R) are insulin-dependent diabetics, yet neither had an active diabetes care plan. As a result of this deficient practice, these residents were placed at risk for a decline in their quality of life and were prevented from attaining their highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) Cross-reference to F689 Accident Hazards. A review of R5's CP revealed no active care plan developed for Activities of Daily Living (ADLs), which would include interventions addressing her mobility and transfer needs. Resident (R)5 is a [AGE] year-old female admitted to the facility on [DATE] for long-term care. Her active diagnoses include insulin-dependent diabetes, and chronic kidney disease. A review of R5's electronic health record (EHR) revealed that she had a stroke with functional decline on 08/05/24. A review of R5's CP noted no resident-specific care plan for her diabetes and/or diabetes management. A review of her CP history revealed a resident-specific diabetes care plan titled: LTC [long term care] Diabetes Mellitus IPOC [individualized plan of care] that was discontinued on 06/04/24. On 09/10/24 at 09:26 AM, a concurrent interview and record review was done with the MDS (Minimum Data Set) Coordinator (MDSC) in Conference Room C. After reviewing R5's CP, MDSC confirmed that R5's diabetes care plan had been discontinued on 06/04/24 but could not explain why. MDSC stated she would look into whether R5 had a diabetes care plan between 06/04/24 and her stroke on 08/05/24. On 09/10/24 at 10:57 AM, an interview was done with MDSC at the Nurses' Station. When asked about CP management, MDSC stated that she oversees the residents' care plans, but any licensed staff can initiate and discontinue them. When asked what oversees entails, MDSC responded that she reviews each resident's care plan at least every 90 days. On 09/10/24 at 11:03 AM, during a concurrent record review and interview with the Quality Management Nurse (QMRN) at the Nurses' Station, QMRN confirmed that R5 had no Diabetes Care Plan since 06/04/24. QMRN showed MDSC and the State Agency documentation in the EHR that revealed that although a Diabetes Care Plan had been entered into the EHR on 08/15/24, it had never been initiated, so was not active. Review of the facility's Comprehensive Care Plan policy and procedure, last updated 01/25/24, noted the following: C. The planning for care, treatment and services shall include the following . Individualized to meet the needs of the resident with measurable objectives describing the steps towards achieving the resident's goals . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	37954 2) On 09/04/24 during review of R1's EHR found she is a [AGE] year-old who was admitted to the facility on [DATE]. Review of R1's medications revealed she is receiving insulin daily with her morning meal to treat her diabetes. Review of R1's CP did not reveal a current CP and no interventions for resident's diabetes. On 09/09/24 at 11:30 AM, requested a copy of R1's Diabetes CP from the MDSC. On 09/10/24 at 11:15 AM, MDSC provided a copy of R1's CP. Review of R1's CP found R1's LTC Diabetes Mellitus IPOC (Completed) and had Last updated on 08/24/23 at 12:15 HST by MDSC name. Outcomes and Interventions were either discontinued or met for R1. Concurrent interview with MDSC confirmed R1 did not have a Diabetes CP.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to ensure 1 of 13 residents sampled (Resident 5) was free from accident hazards. Despite having a history of falls, an identified recent stroke with functional decline, and requiring a two-man assist for transfer, staff failed to lower Resident (R) 5's bed until her feet were touching the floor prior to manually transferring her from her bed to a shower chair, placing her at risk for an avoidable fall and/or injury. In addition, the facility failed to develop and implement a care plan for R5 that included/addressed her mobility and transfer needs. This deficient practice has the potential to affect all residents at the facility who require assistance to stand or transfer. Findings include: Resident (R)5 is a [AGE] year-old female admitted to the facility on [DATE] for long-term care. Her diagnoses include diabetes (added to diagnosis list at admission), chronic kidney disease (last updated on diagnosis list [DATE]), recurrent falls (last updated in 2019), decreased transfer ability (last updated in 2023), and history of stroke (last updated in 2022). During a review of R5's electronic health record (EHR), the following was noted under a PT (Physical Therapy) Evaluation and Treatment done on [DATE]: . requires MAX A [maximum assistance] today for sit to stand and stand pivot transfer secondary to RLE [right lower extremity] weakness . at an increased high fall risk than she was previously . While the following was noted under an OT (Occupational Therapy) Evaluation done on [DATE]: Toilet Transfer: [needs] Total assistance . Shower Transfer: [needs] Total assistance . currently max A [maximum assistance] - [to] dependent for ADLs [activities of daily living such as transferring] . On [DATE] at 08:46 AM, an observation was done of Certified Nurse Aide (CNA)2 and CNA5 getting R5 ready to be transferred from her bed to a shower chair. R5 was noted to be wearing a t-shirt, an adult disposable brief, and a pair of sneakers, as her feet dangled above the floor while seated at the edge of the bed. While CNA5 supported R5 under her right armpit, CNA2 supported R5 under her left armpit. CNA2, being the closest to the bed controls, lowered the bed to a height where R5's feet remained dangling above the floor. As CNA5 and CNA2 readied to lift R5 off the bed from under each armpit, this Surveyor stopped them and asked if the bed could be lowered any more as R5's feet were not touching the floor. CNA2 lowered the bed until R5's feet touched the floor, then they transferred her to the shower chair lifting her under both armpits. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 08:50 AM, an interview was done with CNA2 at the bedside while CNA5 took R5 to the shower room. When asked if they usually lower a resident's bed to the lowest setting prior to assisting a resident for transfer, CNA2 responded, not always, because the bed goes really low, and it can become difficult for a resident to stand [from the lowest setting]. While CNA2 did agree that the bed should be lowered enough so that the resident's feet can touch the ground, she explained that she didn't do that for R5 because she cannot bear weight. When asked if they should be using a mechanical lift for safety when transferring a resident that cannot bear weight, CNA2 stated that sometimes R5 can bear a little weight and assist with a transfer, but most times she cannot, so they make sure they have two (2) staff to transfer her at all times. When asked again about using a mechanical lift when they know a resident cannot assist with the transfer, CNA2 responded they haven't recommended mechanical transfers for her yet. When asked if an order or a recommendation for a mechanical transfer was necessary in order to use a mechanical lift, CNA2 answered no, and agreed that they can use it whenever they feel it is necessary. On [DATE] at 11:34 AM, an interview was done with the Minimum Data Set Coordinator (MDSC) at the Nurses' Station. MDSC confirmed that R5 had a stroke on [DATE] and as a result experienced a decline in functional abilities. MDSC also confirmed that since [DATE], at times R5 can assist with a transfer in and out of bed, but most times she cannot. While MDSC agreed that staff should use their judgement to use a mechanical lift to transfer a resident safely, she stated that 2-man manual transfers can be done safely with R5 if staff lift her under the arm and under the leg on each side. A review of R5's Comprehensive Care Plan (CP) revealed no active care plan developed for ADLs, which would include interventions addressing mobility and transfer needs. A review of the facility's Safe transfers With Use of Mechanical Lift policy and procedure (P&P), and Safe Transfers Without Use of Mechanical Lift P&P, revealed the following: Mechanical lifts are to be used for all residents that cannot assist with transfers.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43245 Based on observation, interview, and record review, the facility failed to ensure all medications used in the facility were labeled in accordance with professional standards, including medication parameters for administration. Proper labeling of medications is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility who take medications. Findings include: 1) On 09/06/24, beginning at 08:00 AM, medication pass observations were done with Registered Nurse (RN)6. At 08:01 AM observed RN6 preparing medications for Resident (R)11, who had a blood pressure that morning of 82/45 and when rechecked, 88/51. Observed the Metolazone 10 milligrams (mg) that RN6 prepared had a medication label on the blister pack that read: HOLD FOR SBP [systolic blood pressure] < [less than] 100 OR SYMPTOMATIC HYPOTENSION [low blood pressure]. Handwritten in red pen next to that was the following: SBP<80. Observed the Furosemide 40 mg that RN6 prepared had a medication label on the blister pack that read: HOLD FOR SBP<90. Handwritten in both black and blue ink to the left of the medication label was the following: FYI: Hold < SBP 80. At 10:23 AM, concurrent record review and interview was done with RN6 at the medication cart. Regarding the Metolazone, record review confirmed that the order decreasing the parameter from an SBP<100 to an SBP<80 was changed on 06/27/24. RN6 confirmed that the medication blister pack she used that morning was sent from the pharmacy on 08/01/24. Regarding the Furosemide, record review confirmed that the order decreasing the parameter from an SBP<90 to an SBP<80 was also changed on 06/27/24. RN6 confirmed that the medication blister pack she used that morning was sent from the pharmacy on 08/19/24. RN6 could not explain why the pharmacy labels on the medications did not match the provider order(s) from over a month ago. 2) On 09/06/24 at 08:31 AM, observed RN6 preparing medications for R18, who had a blood pressure that morning of 145/58. Observed that the Losartan 100 mg that RN6 prepared had a medication label on the blister pack that read: HOLD FOR SBP<100. At 10:19 AM, concurrent record review and interview was done with RN6 at the medication cart. Record review confirmed that the original order for the Losartan on 10/30/23 was with parameters of Hold for SBP<110. RN6 confirmed that the parameters had never been changed. RN6 also confirmed that the medication blister pack she used that morning was sent from the pharmacy on 08/25/24. RN6 could not explain why the pharmacy label on the medication did not match the provider order. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Medication Administration policy and procedure, last updated 01/14/23, revealed the following: . RN [registered nurse] . Acknowledges and verifies orders in Electronic Medical Record (EMR). . Pharmacist . Independently verifies the Physician's order at the time of validating medication into the patient profile.

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on observation, record review, and interview the facility failed to assure kitchen staff used non-expired Hydrion test strips to test the kitchen's three-compartment sink for proper sanitizer level to assure sufficient concentration of sanitizing solution is present to effectively clean and sanitize dishware and failed to assure the kitchen dishwasher water temperature was used and logged at 180 degrees Fahrenheit (F) or more during the rinse cycle, failing to assure dishware and silverware were heat sanitized. This deficient practice puts all residents, staff, and visitors, who eat their meals at the facility, at risk for foodborne illness. The State Agency (SA) identified an Immediate Jeopardy (IJ) at 483.60 (F812) on [DATE] at 10:12 AM. The facility failed to follow the proper sanitizing practices for the dishes and silverware to prevent the outbreak of foodborne illnesses as evidenced by final rinse temperatures of the water in the High Temperature Dishwasher (using heat sanitization) that were below the temperatures recommended for safety by the U.S. Department of Health and Human Services, Public Health Services, Food and Drug Administration Food Code (https://www.fda.gov/media/110822/download), in addition to not monitoring that the proper temperatures were being maintained. Widespread serious harm is likely to all residents using facility dishware and/or utensils due to risk of transmission of enteral pathogens related to improper sanitization. On [DATE] at 12:41 PM, the Regional Chief Nursing Executive and the Regional Chief Quality Officer were notified in writing of the IJ and provided with the IJ template. Both signed the template to attest receipt of the notice. On [DATE] at 02:23 PM, the SA finalized onsite verification that the IJ Removal Plan, provided by the facility and approved by the SA, had been implemented. Although the SA confirmed IJ Removal, a pattern of level 2 deficient practices at F812 remained. Findings include: On [DATE] at 10:00 AM, started initial tour of the kitchen with Food Service Manager (FSM) and Executive Sous Chef (ESC). At 10:03 AM observed the three-compartment sink that was just filled up with water and sanitizer solution. At this time, requested staff test the sanitizing solution. Kitchen staff had a container of Hydrion test strips that she used that did not have the picture of the colored strip to compare the test strip to, she stated it got lost. Requested ESC get another packet of the Hydrion test strips for testing. New test strips ESC brought out were found to be expired with expiration date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 10:12 AM, observed the kitchen dishwasher running a wash and rinse cycle. Dishwasher showed the temperature of the washing cycle was at 150 degrees F temperature or higher, and the rinse cycle showed P2. Reviewed temperature logs for the dishwasher at this time and noticed staff wrote P2 for rinse temperature on the log for all of [DATE] and [DATE], up to today's date ([DATE]). Inquired of ESC what P2 meant, and ESC stated she did not know. Observed thermometer behind the dishwasher appeared broken as it was not registering the high temperature water running through the dishwasher. ESC stated, maintenance is working on this. ESC used a meat thermometer in the dishwasher to test the rinse temperature and found the thermometer did not register past 178 degrees F. SA requested ESC to call maintenance staff to come to the kitchen for an interview. Interview was conducted with Maintenance Staff (MS)1 and inquired if thermometer on dishwasher was broken, and he stated he has to replace the heat line and has the parts but has not had time to do it. MS1 was able to show the second boiler booster, which is located under the counter to the right of the dishwasher. Thermometer for the booster is located above the booster and at this time found it was at 170 degrees F. MS1 stated staff have to run the dishwasher one or two times for the temperature to raise up to 180 degrees F or more. Requested copies of August and September dishwasher temperature logs from ESC which she provided. On [DATE] at 11:45 AM ESC provided copies of Dishmachine Temperature Records from [DATE] which found staff started writing P2 on the dishmachine temperature rinse on [DATE]. Review of the monthly records found temperature rinse had temperatures below 180 degrees F from [DATE] to [DATE]. P2 was documented for temperature rinse logs from [DATE] and ongoing through [DATE]. Dishmachine Temperature Records states Temperatures (150 F and above for Wash) (180 F and above for Rinse). The [DATE] - [DATE] Dishmachine Temperature Records did not have any Re check Temp. or Plan of Action (Maintenance Notified) filled out for the out of range temperatures or P2. On [DATE] at 12:05 PM requested facility policy for dish washing from the kitchen manager. On [DATE] at 12:20 PM kitchen manager provided a copy of facility policy Washing Dishes with an effective date of February 23, 2021 which states III. Procedure: 6. The supervisor must maintain a dish machine temperature log to ensure that temperatures meet the established standards. Temperatures are taken by the food service employee as [sic.] a designated time and logged.