

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Legacy Hilo Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Kaumana Drive Hilo, HI 96720	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245</p> <p>Based on record review and interview, the facility failed to ensure nursing staff had the appropriate competencies and skill sets to provide nursing services that assured resident (R) safety for 1 of 6 residents sampled (R1). As a result of this deficient practice, R1 was placed at risk of a decrease in her physical well-being related to receiving morphine sulfate (a strong narcotic most commonly used to treat moderate to severe pain) on a routine basis, scheduled every one hour, as opposed to being used as needed.</p> <p>Findings include:</p> <p>Resident (R)1 was an [AGE] year-old female admitted to the facility on [DATE]. On 05/23/24, R1 was admitted to hospice for end-of-life care. On 05/28/24, R1 passed away at the facility while on hospice. On 06/24/24, the State Agency (SA) received an anonymous complaint (ACTS #11034) regarding the care R1 received at the end of her life. Amongst the allegations made was a concern that R1 had received too much morphine sulfate on 05/26/24.</p> <p>On 07/09/24, a review of R1's electronic health record (EHR) revealed the following progress notes:</p> <p>05/26/24 Hospice Nurse Progress Note: . On-call Visit . ORDERS: Morphine 10 mg [milligrams] Q1H [every one hour] PRN [as needed] .</p> <p>05/26/24 02:59 PM Facility Nursing Progress Note: New Orders Hospice nurse . spoke to APRN [advanced practice registered nurse] . from Hospice with the following recommendations: . Roxanol [morphine sulfate] 10 mg Q1H prn for pain/SOB [shortness of breath]. The Roxanol order was updated.</p> <p>Further review of R1's EHR revealed the following physician orders entered for morphine sulfate:</p> <p>05/24/24: Morphine 20 mg/ml (milligrams per milliliter) 0.25 ml (5 mg) every one to two hours PRN (as needed) for pain and shortness of breath (order was discontinued on 05/26/24 at 02:53 PM).</p> <p>05/26/24 02:53 PM: Morphine 20 mg/ml 0.5ml (10 mg) every one hour for pain and shortness of breath.</p> <p>05/26/24 09:39 PM: Morphine 20 mg/ml 0.5ml (10mg) every one hour as needed for pain and shortness of breath.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Legacy Hilo Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Kaumana Drive Hilo, HI 96720	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of R1's medication administration record (MAR) revealed that on 05/26/24, between 02:53 PM (when R1's morphine sulfate order was doubled from 5 mg to 10 mg and changed from as needed to scheduled every one hour) and 09:39 PM (when the order was clarified and changed to as needed), R1 was given morphine sulfate at 04:32 PM, 05:00 PM, 06:31 PM, and 09:00 PM. The MAR documents that her family declined/refused the 07:00 PM and 08:00 PM doses and requested that the order be clarified. After the order was clarified and changed to as needed (at 09:39 PM), R1 did not receive any further morphine sulfate until the next morning.</p> <p>On 07/10/24 at 11:01 AM, an interview was done in the Conference Room with Resident Care Manager (RCM)1. RCM stated that there was a data entry error made on the 05/26/24 02:53 PM order, and that the order should have reflected that it was PRN and not scheduled every one hour. At a second interview done at 11:25 AM, RCM1 agreed that he would expect a nurse to question/clarify any order scheduled for every one hour, but especially a narcotic.</p> <p>On 07/11/24, a review was done of the Nurse Competency checklists for the Licensed Practical Nurse (LPN)1 who took and incorrectly transcribed the morphine sulfate order on 05/26/24, and the Registered Nurse (RN)1 who administered the morphine sulfate every hour times 3 hours, without clarifying the order until it was questioned by a family member. LPN1, employed at the facility as an LPN since 03/03/24, had been initialed off in every topic area on the checklist, including Documentation of Telephone/verbal orders, by RCM1 on 03/04/24 and 03/05/24. What was noted to be lacking on the checklist, however, was that none of the individual skills within each topic area had been checked off as completed, and neither were the assessment methods (i.e., verbalized understanding, return demonstration, observed in clinical area, documentation review). RN1, employed at the facility as an RN since 04/08/24, had been checked off in every skill area under the topic of Medication Management, by the Staff Development/Educator on 04/10/24, however, the only assessment method checked was Verbalized understanding.</p> <p>On 07/11/24 at 10:27 AM, a phone interview was done with the Staff Development/Educator (SD). During a concurrent review of both Nurse Competency Checklists, SD agreed that neither checklist had been completed as it should be. For LPN1, SD stated, everything should be checked off [with regard to the individual skills within each topic area], and agreed that some type of assessment method should also be checked off. For RN1, SD verified she was the one who checked off every box under each topic area and individual skill, however, she did not provide the one-on-one training, so did not feel comfortable checking off any of the assessment methods. SD agreed that for the topic of medication management, the preferred assessment methods to ensure competency would be observed in clinical area or return demonstration. SD confirmed that the assessment method(s) should have been checked off by her one-on-one trainer. SD could provide no explanation why RN1's one-on-one trainer had not been the one to check her off on each skill, or why she, as the SD, had checked/initialed off on all the individual skills when she was not the one-on-one trainer.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Legacy Hilo Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Kaumana Drive Hilo, HI 96720	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245</p> <p>Based on record review and interview, the facility failed to ensure pharmacy services included a thorough process to assure accurate reconciliation and accounting for all controlled medications in order to promptly identify loss or potential diversion.</p> <p>Findings include:</p> <p>Resident (R)1 was an [AGE] year-old female admitted to the facility on [DATE]. On 05/23/24, R1 was admitted to hospice for end-of-life care. On 05/28/24, R1 passed away at the facility while on hospice. On 06/24/24, the State Agency (SA) received an anonymous complaint (ACTS #11034) regarding the care R1 received at the end of her life. Amongst the allegations made was a concern that R1 had received too much morphine sulfate on 05/26/24.</p> <p>On 07/09/24, while investigating the complaint, a review of R1's medication administration record (MAR) and progress notes was done while comparing it to the Controlled Drug Record (log) for the morphine sulfate. Several discrepancies were found while attempting to reconcile the MAR and log. The MAR documents 0.50 milliliters (mls), equivalent to 10 milligrams (mg) of morphine sulfate was administered on 05/26/24 at 09:00 PM, however there is no corresponding sign out on the log between 06:30 PM (administered at 06:32 PM) and 12:55 AM the next morning. Progress notes and the log indicate 0.50 mls (10 mg) was signed out, half the dose was wasted per family request, and 5mg was given on 05/27/24 at 12:55 AM. Review of the MAR reveals the first dose administered on 05/27/24 was documented as given at 07:50 AM, but the charted date [and time] in the comments for that dose is 05/27/24 02:04 AM. No 12:55 AM dose was documented on the MAR. On the back of the log are documentations of refusals of half the ordered dose, requiring a waste of half of what was signed out, three times on 05/27/24 and twice on 05/28/24. The MAR reflects a half dose was administered only once on 05/27/24 and no occurrences on 05/28/24.</p> <p>On 07/10/24 at 11:01 AM, an interview was done with Resident Care Manager (RCM)1 in the Conference Room. When asked what the process was for narcotic reconciliation and accounting, specifically who should be reviewing the narcotic logs, RCM1 stated that it is the responsibility of the RCM to review and reconcile all the narcotic logs at the end of every month. RCM1 confirmed he did not review/reconcile the narcotic log for R1's morphine sulfate and stated that he should have.</p>		