Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125014	A. BUILDING: RECEIVED B. WING 2016 FEB 24 P 2:34	01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA RETIREMENT RESIDENCE	1434 PUNAHOU STREET HONOLULU, HI 96822 STATE OF HAWAII DOH-OHCA MEDICARE

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4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on resident and family interviews, the facility failed to promote care for residents in a manner to maintain and enhance each resident's dignity and respect for 2 of 26 Stage 2 residents. (Resident #10, Resident #22) Findings include: [redacted]	4 115	11-94.1-27(4) Resident rights and facility practices Arcadia Retirement Residence (ARR) is committed to ensure that care for residents is provided in a manner that maintains and enhances their dignity and respect. Resident #22 expired [redacted] Resident #10 was interviewed [redacted] by the Administrator to discuss concerns and to assure resident that ARR is committed to maintaining [redacted] dignity and will assure that this issue will not recur. Resident indicated that [redacted] could not recall when this had occurred, who the staff member was and did not find the comment offensive. Resident further elaborated that he/she felt safe and does not feel threatened in any way physically or emotionally. The Director of CNA Services and CNA Supervisor met with and provided training for all HCC CNA staff to address the importance of: 1) appropriate communication with residents, 2) providing care that maintains resident dignity in a respectful manner, and 3) responding promptly to call bells. A follow-up retraining will be provided to all licensed nurses and CNA staff on communicating with residents, respecting their dignity, and the importance of prompt responses to call bells. All participants will sign a Training Acknowledgement Form, acknowledging their attendance of the training and understanding of their responsibilities. Call bell response time reports in the InControl nurse call system will be analyzed and reviewed weekly at the IDT meeting which is held every Tuesday. Prolonged response times will be identified and investigated to determine causative factors and interventions to prevent recurrence.	1/31/16 2/19/16 2/6/16-2/24/16 3/18/16 2/23/16 and Ongoing

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Dan Marnell — NHA — 2/24/2016

[redacted]

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4 136	Continued From page 1	4 136	To further assure that the deficient practice does not recur the following measures have been instituted:	
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations, electronic medical record (EMR) and medical record (MR) reviews, and staff interviews, the facility failed to implement interventions including adequate supervision, consistent with resident's needs and plan of care to reduce the risk of an accident for 1 of 26 residents (Resident #39) in the Stage 2 survey sample and maintaining acceptable water temperatures. [redacted]	4 136	1) Resident and family interviews will be conducted through the facility's abaqis quality assurance and quality improvement survey. Abaqis surveys will be conducted bi-annually. 2) Currently, Social Services conducts Resident Rights surveys for all residents within 7-10 days of admission and then annually. Starting in early March 2016, all residents will receive a Resident Rights survey quarterly according to their care plan schedule. The IDT will review and analyze Resident Rights surveys quarterly to identify trends and opportunities for improvement. 3) Director of CNA Services and CNA Supervisor will conduct weekly observations during resident care and response to call bells and provide immediate feedback to staff as appropriate. Ongoing monitoring and evaluation of resident satisfaction will be completed by the Administrator, DON, and Director of Social Services through quarterly resident care plan meetings, quarterly Family Council meetings, and monthly Resident Council meetings. 11-94.1-30 Resident care ARR is committed to ensure to implement interventions including adequate supervision, consistent with resident's needs and plan of care to reduce the risk of an accident as well as maintaining acceptable water temperatures.	April 2016 and October 2016 March 1, 2016 and Ongoing Care Plans-2/24/16 Ongoing Weekly Resident Council-2/29/16 and Ongoing Monthly Family Council-3/23/16 and Ongoing Quarterly

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4 136	Continued From page 2 [redacted]	4 136	Per facility practice, care plan updates are completed shortly after each fall, however due to staff responsible for this was on vacation and a miscommunication as to whose responsibility it was to follow-up on this, there were no updates completed timely. For resident #39, late entries to the Care Plan Update Sheet were made for the falls that occurred [redacted] to document that the falls occurred indicating interventions to reduce the risk of falls, including adequate supervision, that were initiated/developed to prevent recurrence.	1/28/16
			Per facility protocol, hourly rounding for the subsequent 24 hours is to be initiated for all falls to reduce the risk of falls. A review of fall documents that took place [redacted] for resident #39, it was determined that hourly rounding by facility staff was initiated to address the 4 P's: Pain, Potty, Positioning, and Possessions and to assure adequate supervision during transfers and ambulation as required by resident.	12/24/15 1/2/16 1/4/16
			The fall that took place [redacted] was reviewed by the Falls Committee [redacted] to identify root causes with development of interventions including adequate supervision is provided. The falls that took place [redacted] were reviewed by the Falls Committee [redacted] to identify root causes with development of interventions including adequate supervision is provided.	12/29/15 1/5/16
			Following the fall that occurred [redacted] resident #39 [redacted] agreed to have a bed alarm placed on the bed. The bed alarm was functioning properly at the time of application and just prior to the fall [redacted] as evidenced by the audible alarm that sounded when the resident was toileted by facility staff just 3 minutes prior to the fall. The bed alarm did not sound when the resident fell as [redacted] who was present at the time of the fall	1/4/16

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4 136	Continued From page 3 [redacted]	4 136	and who was sleeping in the room with the resident, stated [redacted]had unplugged the bed alarm, complaining that it was noisy when the resident was toileted by facility staff just 3 minutes prior to the fall. Education was provided [redacted] re: the purpose of the bed alarm and the risks involved of unplugging the bed alarm and subsequent failure of notification to staff.	
			On 2/8/2016, a Nursing Intervention was entered into the Treatment Administration Record in the resident's Electronic Medical Record, instructing the licensed nurse on each shift to verify the bed alarm is functioning properly.	2/8/16
			Clinical records/Care Plans for all residents who experienced a fall over the past 30 days were reviewed to ensure an entry to the Care Plan Update Sheet was made to document that a fall occurred with documented interventions, including adequate supervision to prevent fall risk and recurrence.	2/22/16
			All residents with a bed alarm were identified and a Nursing Intervention was entered into the Treatment Administration Record in each resident's Electronic Medical Record, instructing the licensed nurse on each shift to verify the bed alarm is functioning properly.	2/8/16
			To prevent recurrence of this deficient practice the following have been instituted:	
			1) To ensure that the Care Plan is updated in residents' records after every fall, the Falls Committee will verify that an entry is made to the Care Plan Update Sheet which documents that a fall occurred and documents interventions that were initiated, including adequate supervision to be provided to prevent recurrence, during the weekly Tuesday meeting.	2/23/16 and Ongoing Weekly

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4 136	Continued From page 4 [redacted]	4 136	2) The QA Nurse will ensure the interventions, including adequate supervision, discussed and developed in the Falls Committee meetings, are implemented and assures outcomes are documented in the resident's Clinical Notes.	2/23/16 and Ongoing weekly
			3) All licensed staff received a training memo from the DON with instructions to verify the bed alarm is functioning properly on every shift and to enter a Nursing Intervention in the Treatment Administration Record of each resident's Electronic Medical Record who have a bed alarm.	2/8/16
			4) The DON or designee will monitor the Administration Capture Exception Report, which detects orders that are not completed or orders that are not documented as being completed, to ensure the licensed staff is checking the bed alarm to make sure it is functioning properly on every shift. It is the responsibility of each nurse to submit the Administration Capture Exception Report to the DON at the end of their shift for review.	2/8/16 and Ongoing
			5) A Quality Assurance checklist was developed to ensure: • After every fall, an entry is made to the Care Plan Update Sheet. • Interventions, including adequate supervision, discussed in the Falls Committee are implemented and documentation is made in the resident's Clinical Notes. • A Nursing Intervention is entered into the Treatment Administration Record in the Electronic Medical Record for all residents who have a bed alarm.	2/19/16
			Ongoing monitoring and evaluation will be conducted by Administrator and DON.	Ongoing
			On 1/29/16 the facility Maintenance Supervisor contacted Alakai Mechanical requesting a technician to come to the facility to adjust the water temperatures on the 2nd and 3rd floors.	1/29/16

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4 136	Continued From page 5 [redacted]	4 136	The technician arrived at approximately 9:00 am and began adjusting the water temperatures. By 7:00 pm temperature readings were between 98-120 degrees Fahrenheit.	
			On 2/1/16 Alakai Mechanical returned to the facility to make further adjustments. After adjustments were made, temperature readings were between 104-117 degrees Fahrenheit.	2/1/16
			On 2/2/16 the Director of Environmental Services met with Alakai Mechanical to review the work that was done and requested that temperatures be set and maintained at 110-115 (+/- 2 degrees Fahrenheit). Further adjustments were made and it was determined that temperatures could be maintained between 104-117 degrees Fahrenheit.	2/2/16
			Beginning on 1/30/16, during CNA "huddles" the CNA Supervisor began in-servicing staff to always test the water temperature with the resident to make sure the resident is comfortable with the water temperature prior to showering. Any concerns raised by residents will be reported to Administrator and Director of Environmental Services.	1/30/16
			The Director of CNA Services and CNA Supervisor met with and provided training for all CNA staff to address water temperatures and testing the temperature with the resident prior to showering. All CNA staff signed a Training Acknowledgment Form, acknowledging their attendance of the training session and understanding of their responsibilities. Training for a CNA on vacation will be completed on 2/26/16.	2/6/16-2/24/16 2/26/16 for the CNA on Vacation
			Effective 2/2/16, Environmental Services staff has been checking the water temperature in every resident room and temperature readings are logged. Temperatures have stabilized not to exceed 120 degrees Fahrenheit or drop below 100 degrees Fahrenheit.	2/2/16 and Ongoing

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4 136	Continued From page 6 [redacted]	4 136	Building system upgrades have been in the works since mid-2014, with plans for initiation in the third quarter of 2016 to maintain temperatures closer to the 110-115 degree Fahrenheit range. Until completion is achieved, the process implemented since 2/2/16 will be adhered to. On 2/5/16, a Hot Water Temperature protocol was developed instructing Maintenance staff to take a temperature reading of the shower and sink for all rooms in the nursing facility on a daily basis. Any temperatures below 110 degrees Fahrenheit or above 115 degrees Fahrenheit will be reported immediately to the Director of Environmental Services for follow-up and action. Ongoing monitoring and evaluation will be conducted by the Director of Environmental Services with ongoing communication with Administrator.	3rd Quarter 2016 2/5/16 Ongoing
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the	4 159	11-94.1-41(a) Storage and handling of food ARR is committed to ensure proper sanitation and food handling practices to prevent the outbreak of foodborne illness. At 8:20 am, the DFS checked the cook's reach in refrigerator's temperature, and it registered at 40 degrees Fahrenheit. Average temperatures between the hours of 7:00 am and 8:00 am are 43 degrees Fahrenheit (see attached). This is due to high-use period for the kitchen as staff is preparing short orders for the dining room.	1/26/16

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4 159	Continued From page 7 proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure proper sanitation and food handling practices to prevent the outbreak of foodborne illnesses. Findings include: [redacted]	4 159	Acceptable ranges of 41 degrees or less is achieved at approximately 60 minutes after peak use period ends. Average temperatures for low use periods are 35-38 degrees F. On 01/26/16 staff was instructed not to leave refrigerator doors propped open when putting items away in the refrigerator so that temperature can be maintained within acceptable range due to concern of maintaining appropriate storage temperature ranges. Cooks document and log temperatures manually twice per day, in addition to the Smart Temps system which records temperatures online every 15 minutes. All Dining Services (DS) staff is responsible to ensure refrigerator doors are closed properly when doing walk-throughs. Temperature readings are recorded every 15 minutes through the Smart temp system and alerts are sent to the DFS and Chef every hour if temperatures are out of recommended ranges. If temperature is consistently out of range, a 4 hour check is performed by DFS or Chef (or designee). If a refrigerator is monitored to be incorrect for more than 8 hours, temperatures will be taken of items and if not within specified ranges, items will be discarded. Items within range will be transferred to a working refrigerator per protocol (see attached). Ongoing monitoring via Smart Temp log and monitor system is being done daily and reports are sent to the DFS and Chef via emails or text messages for review and follow up action when refrigeration temperature is not within acceptable range of 41 degrees F or less. On 1/26/16, DFS removed the refrigerator metal shelves which were identified as brownish in color and Environmental Services sanded down the rust and resurfaced them as a temporary measure. The shelving has no residue and is free of rust stains.	1/26/16 1/26/16

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4 159	Continued From page 8 [redacted]	4 159	On 1/26/16, all shelves in all refrigerators and freezers were checked and found free of any residue and/or rust.	1/26/16
			On 01/26/16, DFS in-serviced staff on duty on proper cleaning of refrigerators and to report deterioration of shelving or any part of the refrigerators immediately.	1/26/16
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on electronic medical record reviews (EMR), medical record reviews (MRR), and staff interviews, the facility failed to ensure that 1 of 26 residents (Resident #39) in the Stage 2 survey sample had a comprehensive care plan. Findings include: [redacted]	4 174	On 02/03/16 Stainless steel shelving was ordered to replace all shelving in current refrigeration, except the cook's front line refrigerator which is completely being replaced with stainless steel shelving installed. The new cook's line refrigerator was ordered by the DFS and will arrive (with replacement shelving for other refrigeration) between 03/10/16-03/24/16.	2/3/16
			Dietary Coordinator (DC) adjusted internal audit to ensure refrigeration is free from rust, mildew and debris on 02/04/16. Cleaning of refrigerators was added to the maintenance log to ensure that refrigerators are kept free from rust, mildew and debris, monitoring of cleaning of refrigerators will be completed by Chef on a weekly and monthly basis, and documented.	2/4/16
			Effective 02/10/16 internal audits will be or have been conducted twice daily by DS Supervisors and Lead Cooks in addition to the quarterly sanitation audit done by the RD. All Audits will be reviewed and analyzed by DFS and DC to determine need for process improvement and further education/training of staff. Ongoing monitoring and evaluation to be conducted by DFS and DC.	2/10/16

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4 174	Continued From page 9 [redacted]	4 174	DFS directed staff that opened the egg whites to properly label and date the egg whites according to protocol on 01/26/16 (see attached).	1/26/16
			DFS followed up with vendor regarding egg white shelf life on 01/27/16. Vendor responded on 02/01/16 with the following information: (1 year freezer shelf life; 84 day refrigerator shelf life, unopened). Per protocol, once egg products are opened, they shall be used within 3 days and appropriately labeled on the respective carton.	2/1/16
			DC researched new labels to help enforce current labeling protocol on 01/27/16, and was able to complete a cost analysis against current products on 01/29/16. New labels were purchased on 02/1/16 (arrived 02/8/16).	2/9/16 and Ongoing
			DFS and DC in-serviced staff (see attached) on labeling and dating protocols and introduced the new labels, which were implemented on 02/09/16, one day after new labels arrived to the facility.	2/9/16
			DC updated internal audit to ensure labeling protocol will be checked/reviewed and is being followed.	2/4/16
			Internal audits will be conducted twice daily by DS Supervisors and Lead Cooks in addition to the quarterly sanitation audit done by the RD.	2/10/16 and Ongoing
			Audits will be reviewed and analyzed by DFS and DC to determine need for process improvement and further education/training of staff.	
			Ongoing monitoring and evaluation to be conducted by DFS and DC.	2/9/16
			On 1/26/16, after the initial reading of 100 PPM, at approximately 8:32am (time) DFS drained the sink, refilled it and tested it again. The sanitizing solution remained below the required ppm. An Ecolab service rep arrived ten minutes later and	1/26/16

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4 174	Continued From page 10 [redacted]	4 174	calibrated the sink and replaced the spigot for the sanitizing dispenser to meet required ppm, which then read 250 ppm. All Dishwashers were in-serviced (see attached) by the Ecolab service representative regarding proper procedures on accurate testing for sanitization solution. Dishwashers are to change out sanitization water every 4 hours or more frequently as needed per protocol (see attached). ECOLAB provided new charts and guidelines (which indicate acceptable range of 150-400 ppm) which are posted in the dishroom. Preventative maintenance is done by ECOLAB every two weeks. Reports and documentation are located in the dining services office. DC updated internal sanitation audit to include checking and documenting results of sanitization solution in the three compartment sink twice daily. Dishwashers and DS Supervisors are responsible to check sanitization solution 4 times per day to ensure appropriate ranges and if not within range, will take appropriate action of changing solution or contact Ecolab for further recommendations/action. Ongoing monitoring and evaluation to be conducted by DFS and DC.	2/3/16 and Ongoing 2/3/16 2/4/16

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4 174	Continued From page 11 [redacted]	4 174	11-94.1-43(b) Interdisciplinary care process ARR is committed to ensure that all residents have a comprehensive care plan to meet the identified residents' medical, nursing, and mental and psychosocial needs. Per facility protocol, hourly rounding for the subsequent 24 hours is to be initiated for all falls. A review of fall documents that took place [redacted] for resident #39 it was determined that hourly rounding by facility staff was initiated to address the 4 P's: Pain, Potty, Positioning, and Possessions. The fall that took place [redacted] was reviewed by the Falls Committee [redacted] to identify root causes with development of interventions. The falls that took place [redacted] were reviewed by the Falls Committee [redacted] to identify root causes with development of interventions. Following the fall that occurred [redacted] resident [redacted] agreed to have a bed alarm placed on the bed. The bed alarm was functioning properly at the time of application and just prior to the fall [redacted] as evidenced by the audible alarm that sounded when the resident was toileted by facility staff just 3 minutes prior to the fall. The bed alarm did not sound when the resident fell as [redacted] who was present at the time of the fall and who was sleeping in the room with the resident, stated [redacted] had unplugged the bed alarm, complaining that it was noisy when the resident was toileted by facility staff just 3 minutes prior to the fall. Per facility practice, care plan updates are completed shortly after each fall, however due to staff responsible for this was on vacation and a miscommunication as to whose responsibility it was to follow-up on this, there were no updates completed timely.	12/24/15 1/2/16 1/4/16 12/29/15 1/5/16 1/4/16 1/28/16

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4 175	Continued From page 12	4 175	Therefore, late entries to the Care Plan Update Sheet were made for the falls that occurred [redacted] to document that the falls occurred indicating interventions that were initiated/developed to prevent recurrence.	
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on electronic medical record reviews and staff interviews, the facility failed to attempt to accommodate both the exercise of the resident's rights and the resident's health including care alternatives for 1 of 26 residents (Resident #21) in the Stage 2 survey sample to participate in. Findings include: [redacted]	4 175	On 2/8/2016, a Nursing Intervention was entered into the Treatment Administration Record in the resident's Electronic Medical Record, instructing the licensed nurse on each shift to verify the bed alarm is functioning properly. Clinical records/Care Plans for all residents who experienced a fall over the past 30 days were reviewed to ensure an entry to the Care Plan Update Sheet was made to document that a fall occurred with documented interventions to prevent recurrence. All residents with a bed alarm were identified and a Nursing Intervention was entered into the Treatment Administration Record in each resident's Electronic Medical Record, instructing the licensed nurse on each shift to verify the bed alarm is functioning properly. To prevent recurrence of this deficient practice the following have been instituted: 1) To ensure that the Care Plan is updated in residents' records after every fall, the Falls Committee will verify that an entry is made to the Care Plan Update Sheet which documents that a fall occurred and documents interventions that were initiated to prevent recurrence during the weekly Tuesday meetings. 2) The QA Nurse will ensure the interventions discussed in the Falls Committee meetings and interventions developed in the Care Plan Update are implemented. The QA Nurse will document that the interventions were implemented in the resident's Clinical Notes.	2/8/16 2/22/16 2/3/16 2/23/16 and Ongoing Weekly 2/23/16 and Ongoing Weekly

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4 175	Continued From page 13 [redacted]	4 175	3) All licensed staff received a training memo from the DON with instructions to verify the bed alarm is functioning properly on every shift and to enter a Nursing Intervention in the Treatment Administration Record of each resident's Electronic Medical Record who have a bed alarm (see attachment). 4) Hospice Care Plans will be integrated into the facility Care Plan. Hospice Care Plans will be reviewed after each hospice visit to identify any updates or changes. Updates will be integrated into the facility Care Plan in the resident's Electronic Medical Record. Hospice RN participation in facility Care Plan meetings will continue to be encouraged. 5) The DON or designee will monitor the Administration Capture Exception Report, which detects orders that are not completed or orders that are not documented as being completed, to ensure the licensed staff is checking the bed alarm to make sure it is functioning properly on every shift. It is the responsibility of each nurse to submit the Administration Capture Exception Report to the DON at the end of their shift for review. 6) A Quality Assurance checklist was developed to ensure: • After every fall, an entry is made to the Care Plan Update Sheet. • Interventions discussed in the Falls Committee are implemented and documentation is made in the resident's Clinical Notes. • A Nursing Intervention is entered into the Treatment Administration Record in the Electronic Medical Record for all residents who have a bed alarm. • Hospice Care Plan updates are integrated into the facility Care Plan in the resident's Electronic Medical Record. Ongoing monitoring and evaluation will be conducted by Administrator and DON.	2/8/16 2/24/16 and Ongoing 2/8/16 and Ongoing 2/19/16 and Ongoing

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4 175	Continued From page 14 [redacted]	4 175	On 1/30/2016, a review was completed of resident #39 clinical record/care plan and an entry to the Care Plan Update Sheet was made to include the need for monitoring of the effectiveness of the medications and potential side effects [redacted] On 2/22/16 an update entry to the Care Plan Update Sheet was made to include the indication for use to address resident's behaviors [redacted]	1/30/16 2/22/16
			On 2/4/2016, a review was conducted for all residents who have an order for routine and/or PRN psychotropic medications (antipsychotic, antianxiety, antidepressant, and/or hypnotic) and entries were made to each resident's Care Plan Update Sheet regarding monitoring of the effectiveness and potential side effects of respective medications. On 2/22/16 an update entry to the Care Plan Update Sheet was made to include the indication for use of the medication.	2/4/16 2/22/16
			On 2/3/2016, the DON distributed a training memo to all licensed nurses to inform them of the need to document and monitor resident reactions to routine and/or PRN psychotropic medications (antipsychotic, antianxiety, antidepressant, and/or hypnotic) and to make entries into their daily clinical notes (see attachement).	2/3/16
			To prevent recurrence of this deficient practice: 1) For all residents who receive routine and/or PRN psychotropic medications (antipsychotic, antianxiety, antidepressant, and/or hypnotic): Licensed staff will monitor for effectiveness of the medication in treating the symptom it was ordered for, possible side effects, and any non-pharmacological interventions that were tried prior to the administration of the medication. Daily documentation will be made in the residents Clinical Notes until the Mood and Behavior Monitoring Log is implemented on 3/18/16, following training of all licensed nurses.	2/3/16

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4 175	Continued From page 15 [redacted]	4 175	2) DON has developed a new Protocol: Psychotropic Drug Use which provides guidance to licensed nurses on reporting of resident reactions and drug effectivity. DON also developed a Mood and Behavior Monitoring Log to monitor and document behaviors, pharmacological and non-pharmacological interventions, effectiveness of the intervention, and possible side effects or adverse reactions. (see attached)	2/7/16
			3) All licensed nurses will receive training on the Psychotropic Drug Use protocol, the Mood and Behavior Monitoring Log, and guidelines indicating when to update the resident's PCP or Consultant Geriatric Psychiatrist regarding behaviors and effectiveness of the psychotropic medication. All licensed nurses will sign a Training Acknowledgment Form, acknowledging their attendance of the training session and understanding of their responsibilities.	3/18/16
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure that medications are labeled properly, discard expired medications, and expiration dates are indicated and visible on the pharmacy label. Findings include: [redacted]	4 197	4) The Mood and Behavior Log will be reviewed, analyzed and used by Social Services to monitor resident behaviors and assist in implementing non-pharmacological interventions.	3/18/16 and Ongoing
			5) For all residents receiving psychotropic medications (antipsychotic, antianxiety, antidepressant, and/or hypnotic): The IDT will review the Mood and Behavior Log monthly and/ or in the event of a significant change in condition for appropriateness of continued use of the psychotropic medication.	3/18/16 and Ongoing
			6) The facility Consultant Geriatric Psychiatrist is available to perform psychiatric evaluations, medication monitoring, and staff education.	
			7) Continue review by the Associate Medical Director as part of each MDS assessment of a resident, discussion with IDT to determine if the use of the psychotropic medication is necessary, if a gradual dose reduction is indicated,	2/24/16 and ongoing per MDS Assessment Schedule

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4 197	Continued From page 16 [redacted]	4 197	or other non-pharmacological least restrictive interventions should be implemented/considered. As necessary the Associate Medical Director may contact the resident's PCP.	
			8) The facility Consultant Pharmacist conducts monthly drug regimen reviews to review documentation of monitoring and discusses with licensed nurses effectivity of medications and interventions provided. Based on the findings, the Consultant Pharmacist makes recommendations for discontinuation or gradual dose reductions of psychotropic medication use to primary care physicians when appropriate.	Ongoing Monthly
			9) The Consultant Pharmacist also tracks/trends, and presents findings at the quarterly Quality Assurance meetings, the usage of psychotropic medications within the facility, comparison with state and national data and achievement of facility's goals towards reduction of Antipsychotic Drug use.	Ongoing Quarterly
			10) A Quality Assurance checklist was developed to ensure: • The Care Plan is updated for all residents who receive psychotropic medications addressing indication for use, monitoring the effectiveness and potential side effects. • The Mood and Behavior Log is reviewed and analyzed monthly or in case of a significant change in condition.	2/19/16 and Ongoing
			Ongoing monitoring and evaluation will be conducted by Administrator and DON.	Ongoing
	[redacted]		11-94.1-43(c) Interdisciplinary care process ARR is committed to ensure that all residents are accommodated the right to participate in the planning of their care and any changes in their care regimen/alternatives.	

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4 197	Continued From page 17 [redacted]	4 197	Currently, care plan meetings are held with all residents on a quarterly basis. The care plan meeting provides a forum for the IDT to update the resident and/or resident family member, POA, or representative on how the resident is doing. It also gives residents the opportunity to ask questions and provide feedback about the care and services provided to them. Residents are invited and encouraged to attend their care plan meeting. If a resident's ability to make decisions about care and treatment is impaired, the resident's family member, POA, or representative is also invited and encouraged to attend or to participate by teleconference. If there is no participation on behalf of the resident, Social Services provides the resident's family member, POA, or representative an update of the care plan meeting via telephone or secured email. The social worker providing the update asks if there are any comments/questions/concerns as applicable. The social worker documents in the resident's Clinical Notes that and update was provided and who is was provided to. A review of resident #21's clinical notes was completed [redacted]	2/20/16
			On 2/4/16 all residents' orders for routine and/or PRN psychotropic medications (antipsychotic, antianxiety, antidepressant, and/or hypnotic) were identified. Late entries to the Care Plan Update	2/4/16

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4 269	Continued From page 18	4 269	Sheet were made to include monitoring of the effectiveness of their medications and possible side effects.	
4 269	11-94.1-65(d)(6) Construction requirements (d) The facility shall have adequate toilet and bath facilities: (6) An adequate supply of potable running water shall be provided at all times. Temperatures of hot water at plumbing fixtures used by the residents shall be automatically regulated and shall not be below 100 or above 120 degrees Fahrenheit; This Statute is not met as evidenced by: Based on interviews, observations, and review of water temperature logs, the facility failed to maintain safe water temperatures for resident rooms to prevent injuries to this high risk population. Findings include: [redacted]	4 269	To prevent this deficient practice from recurring: 1. Social services will contact resident, family, POA or representatives to inform them of care plan meeting, its purpose and invite participation. If they are not able to participate, this information will be documented and method of providing communication/information will be developed to assure that resident, family, POA, or representative are informed of residents' status, care provision and/or alternatives and any changes identified. 2. The facility Chaplain, Social Services, and Activities staff is available to assist residents and families with spiritual needs. 3. When significant changes are noted in residents, positive or negative, the resident, family, POA or representative and PCP will be notified immediately. 4. When changes are being considered to be made in the treatment of care, the PCP, resident, family, POA or representative will be notified immediately. Ongoing monitoring and evaluation will be conducted by Administrator and DON. 11-94.1-46(n) Pharmaceutical services ARR is committed to ensure that medications are labeled properly, discard expired medications, and expiration dates are indicated and visible on the pharmacy label. On 2/1/16, a review of the current practice was reviewed to identify gaps or discrepancies that lead to the lack of oversight to ensure that expired medications were discarded. It was identified that night nurses were logging that medications were	2/24/16 and Ongoing 2/24/16 and Ongoing 2/24/16 and Ongoing 2/24/16 and Ongoing Ongoing 2/1/16

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4 269	Continued From page 19 [redacted]	4 269	checked as per our process. However, we failed to implement an audit system to ensure that all processes were being adhered to. On 2/1/16, all medication carts and treatment carts were checked for any expired or soon to expire medications. Any expired medications were removed and discarded per facility process. On 2/9/16, DON issued a training memo to all licenses nurses' entitled Monitoring for Expired Medications (see attachment) outlining process for monitoring and expectations of all staff. To prevent recurrence of the deficient practice the following has been implemented: 1. Effective 2/20/16, weekly medication cart checks will be completed by PharMerica consultant for 4 weeks. 2. On 2/29/16, PharMerica consultant will in-service all nursing staff on the importance and process regarding maintaining medication and treatment carts and expired medications. 3. Effective 2/24/16, QA nurse will highlight expiration dates on each label, which was approved via telephone call with DOH Pharmacist on 2/22/16, for all medications currently in the medication and treatment carts. For all new medications, the licensed nurses receiving the medication deliveries will highlight the expiration date on each label. 4. Effective 2/23/16, DON, ADON or QA nurse will observe medication passes to ensure that medication administration process adheres to facility protocol and nurses are checking to ensure that no expired medications are in the medication and treatment carts. 5. Every nurse administering medications or treatments is responsible for ensuring no expired medications or pharmaceuticals are stored in the	2/1/16 2/9/16 2/23/16 Ongoing

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4 269	Continued From page 20 [redacted]	4 269	medication carts, treatment carts, or medication refrigerator.	
			6. Medication nurses will check each label to ensure that medications are not expired, and that expiration dates are highlighted during each med pass.	Ongoing
			7. Night shift nurses will conduct weekly medication cart, treatment cart, and medication refrigerator checks to ensure no expired medications are being stored. If expired medications are found they are to be removed and discarded per facility protocol. The night shift nurse will complete a Unit Check Medication Log to document the weekly checks are being done. The log will be monitored weekly by the DON or designee.	2/9/16 and Ongoing Weekly
			8. During the weekly review of medications by the night shift nurses, the nurse will tab those medications that will expire within 2 weeks, have them refilled by the pharmacy and establish a tickler system for disposal of the expired medication.	3/18/16 and Ongoing
			9. On 2/9/16, DON developed a new protocol: Medication Quality Control Procedures (see attached), which outlines measures to be taken by licensed staff to ensure no expired medications and pharmaceuticals are stored in the medication carts, treatment carts, or medication refrigerators, which will be implemented on 3/18/16.	2/9/16
			10. Prior to implementation of the Medication Quality Control Procedures protocol, all licensed nurses will receive training and sign a Training Acknowledgment Form, acknowledging their attendance of the training session and understanding of their responsibilities.	3/18/16
			11. Random medication cart, treatment cart, and medication refrigerator checks will be conducted by the DON or designee. Each unit will be subject to a random check at least once per quarter.	3/18/16

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			12. A PharMerica nurse will conduct a monthly medication station audit on each unit to assure medications are properly labeled and stored and that no expired medications are in the medication carts, treatment carts, or medication refrigerators.	Ongoing Monthly
			13. The Consultant Pharmacist will also conduct a monthly medication station audit on each unit to assure medications are properly labeled and stored and that no expired medications are in the medication carts, treatment carts, or medication refrigerators.	Ongoing Monthly
			14. Adherence to facility protocols regarding medication storage will be incorporated into the Performance Management of every licensed staff.	3/18/16
			For resident #56, resident receives all medications from [redacted] ADON called [redacted] Pharmacy to determine the expiration date for all medications dispensed by [redacted] Pharmacy currently in use in the facility. Per [redacted] Pharmacist, their policy is not to indicate the expiration date on the label, and that the expiration date is one year from the dispensing date.	2/5/16
			[redacted] the DOH Pharmacist was contacted and indicated that as [redacted] not under the purview of the State, they are not required to adhere to the HRS 328-16 Drug Labelling.	2/12/16
			On 2/12/16, Consultant Pharmacist called [redacted] Pharmacy to verify the expiration dates of medications in the facility dispensed by [redacted] Pharmacy and received expiration dates. Consultant Pharmacist wrote expiration dates on the label of medications on hand.	2/12/16
			To prevent recurrence of this deficient practice, all facility staff that pick up medications from [redacted] Pharmacy have been instructed to make sure there is an expiration date on the medication	1/29/16

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			label before accepting the medication. If there is no expiration date, staff will ask [redacted] Pharmacist to write expiration date on the label as per instructions provided to facility by [redacted] pharmacist.	
			Should the facility receive a medication from [redacted] Pharmacy without an expiration date, the licensed nurse will contact ARR Consultant Pharmacist to contact [redacted] Pharmacist for verification of the expiration date and add the expiration date to the medication label.	Ongoing
			Ongoing monitoring and evaluation will conducted by Administrator and DON.	Ongoing
			11-94.1-65(d)(6) Construction requirements ARR is committed to ensuring and maintaining safe water temperatures for resident rooms to prevent injury to this high risk population.	
			On 1/29/16 the facility Maintenance Supervisor contacted Alakai Mechanical requesting a technician to come to the facility to adjust the water temperatures on the 2nd and 3rd floors. The technician arrived at approximately 9:00 am and began adjusting the water temperatures. By 7:00 pm temperature readings were between 98-120 degrees Fahrenheit.	1/29/16
			On 2/1/16 Alakai Mechanical returned to the facility to make further adjustments. After adjustments were made, temperature readings were between 104-117 degrees Fahrenheit.	2/1/16
			On 2/2/16 the Director of Environmental Services met with Alakai Mechanical to review the work that was done and requested that temperatures be set and maintained at 110-115 (+/- 2 degrees Fahrenheit). Further adjustments were made and it was determined that temperatures could be maintained between 104-117 degrees Fahrenheit.	2/2/16

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(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) COMPLETE DATE
			Beginning on 1/30/16, during CNA "huddles" the CNA Supervisor began in-servicing staff to always test the water temperature with the resident to make sure the resident is comfortable with the water temperature prior to showering. Any concerns raised by residents will be reported to Administrator and Director of Environmental Services.	1/30/16
			The Director of CNA Services and CNA Supervisor met with and provided training for all CNA staff to address water temperatures and testing the temperature with the resident prior to showering. All CNA staff signed a Training Acknowledgment Form, acknowledging their attendance of the training session and understanding of their responsibilities. Training for a CNA on vacation will be completed on 2/26/16.	2/6/16-2/24/16 2/26/16 for the CNA on Vacation
			Effective 2/2/16, Environmental Services staff has been checking the water temperature in every resident room and temperature readings are logged. Temperatures have stabilized not to exceed 120 degrees Fahrenheit or drop below 100 degrees Fahrenheit.	2/2/16 and Ongoing
			Building system upgrades have been in the works since mid-2014, with plans for initiation in the third quarter of 2016 to maintain temperatures closer to the 110-115 degree Fahrenheit range. Until completion is achieved, the process implemented since 2/2/16 will be adhered to.	3rd Quarter 2016
			On 2/5/16, a Hot Water Temperature protocol was developed instructing Maintenance staff to take a temperature reading of the shower and sink for all rooms in the nursing facility on a daily basis. Any temperatures below 110 degrees Fahrenheit or above 115 degrees Fahrenheit will be reported immediately to the Director of Environmental Services for follow-up and action.	2/5/16
			Ongoing monitoring and evaluation will be conducted by the Director of Environmental Services with ongoing communication with Administrator.	Ongoing