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
	125033	A. BUILDING: _____ B. WING _____	05/27/2016

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STATE OF HAWAII
DOH-OHCA/MEDICARE

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CE	45-090 NAMOKU ST KANEOHE, HI 96744

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4 000	11-94.1 Initial Comments A relicensing survey was conducted at this facility form 5/24 - 5/27/16. At the time of the entrance the resident census was 37.	4 000	**4 090: 11-94.1-16(c) Governing body and management** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The R.N. who read the employee's skin test [redacted] recalled reviewing the skin test and recalled that the skin test was negative. The employee [redacted] who regularly administers and reads skin tests, reported that [redacted] observed [redacted] own skin test as negative with no redness, elevation or induration. The employee recalled the other R.N. reviewing the skin test and finding that it was negative. Contact was then made with the State of Hawaii Department of Health TB Branch for consultation regarding this particular incident. Received information that while it is not good practice, for this incident, the R.N. who read the skin test should document the negative reading and another skin test should not be administered. The R.N. thereafter documented upon the form that the skin test was negative at 0 mm. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 5/26/2016, the records of all staff, whose TB clearance is evaluated via skin test, were audited by the Administrator for completion – specifically that the tests were provided and read as negative. All records were found complete and in compliance with TB clearance requirements. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** (continued)	7/5/2016
4 090	11-94.1-16(c) Governing body and management (c) The facility shall have written personnel policies available to staff, residents, and the public that govern all services provided by the facility and include but are not limited to: (1) Written job descriptions available for all positions. Each employee shall be informed of the employee's duties and responsibilities at the time of employment; (2) Requirements that all employees have appropriate licenses or certification as required by law, and their licenses or certification shall be readily available for examination by the department; (3) Ethical standards of professional conduct that shall apply in the facility; and (4) An organization chart showing the major operating programs of the facility, with staff division, administrative personnel in charge of programs and divisions, and their lines of authority, responsibility, and communication. This Statute is not met as evidenced by: Based on a record review and interview the facility failed to maintain appropriate tuberculosis certification as required by law for one employee. Findings include: [redacted]	4 090		

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beryl Murata — TITLE: Administrator — (X6) DATE: 6-17-16

[redacted]

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4 090	Continued From page 1 [redacted]	4 090	(continued) On 5/26/2016, the Administrator reviewed with the R.N. who read the employee's skin test the importance of documenting information regarding the observed skin test area at the time of the reading. The process for reviewing and tracking TB skin test clearances was revised. The TB Clearance Log was updated to include Date Skin Test Read instead of tracking the clearances by the date the skin test was administered.	
4 112	11-94.1-27(1) 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: (1) The free exercise of rights as a resident of the facility and as a citizen or resident of the United States; This Statute is not met as evidenced by: Based on observation, family interview, staff interview and record review, the facility failed to allow the resident to make a choice about aspects in the resident's life in the facility that are significant to the resident, for 1 of 23 residents in the Stage 2 sample. (Resident #30) Findings include: [redacted]	4 112	**How the corrective action will be monitored to ensure the deficient practice will not recur:** A Focus Audit was developed as a structured format to address the completion of the TB clearance process. The Administrator (or designee) will perform this audit weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. The audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends, and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement. **4 112: 11-94.1-27(1) Resident rights & facility practices** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 6/15/16, Activities Director met with resident #30 to review [redacted] preferences. Following the meeting, the MDS Coordinator amended the resident's care (continued)	7/5/2016

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4 112	Continued From page 2 [redacted]	4 112	(continued) plan to reflect resident #30's preferred sleep and wake times. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** By 7/5/2016 all resident's will be re-interviewed by the Interdisciplinary Team regarding preferred sleep and wake times. By 7/5/2016 resident care plans will be amended to reflect changes in their preferences . **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** Upon admission and on a quarterly basis, the Activities Director will interview each resident to review preferences and customary routine including preferred sleep and wake time. Activities Director will include resident specified preferences on the resident's plan of care. On 6/14/16 Administrator and Director of Nursing provided in-service training to staff regarding the importance of integrating resident preferences into their daily routine and to report any changes in resident preferences by using the NEW ALERT tab in the EMR. The resident's plan of care will then be updated to incorporate the newly identified resident preference. All re-education regarding resident preferences and the need to report changes will be completed by 7/5/2016. During the next Resident Council meeting on 6/27/16, the Activities Director and Social Services Director will review the Resident Right to make choices including the ability to choose daily schedules and as well review the availability of Suggestions / Concerns forms as another means to express preferences. (continued)	

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4 112	Continued From page 3	4 112	(continued) **How the corrective action will be monitored to ensure the deficient practice will not recur:** A Focus Audit was developed to address resident sleep / wake time preferences. This Focus Audit will be used as a structured format to review the completion of resident sleep / wake time preference assessments and that these preferences are integrated into the resident's plan of care. The Activities Director (or designee) will perform this audit weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. Audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends, and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	
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 observation and interview the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Finding includes: [redacted]	4 115	**4 115: 11-94.1-27(4) Resident rights and facility practices** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Director of Nursing re-educated (on 5/26/2016) staff member observed feeding two residents and as well all staff regarding the need to provide individualized 1:1 attention to enhance the dining experience for those residents requiring extensive to total assist. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 6/15/2016, a review of all resident eating scores on the MDS Section G was performed by the MDS Coordinator and (continued)	7/5/2016

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4 115	Continued From page 4 [redacted]	4 115	(continued) Director of Nursing. All residents who scored at an MDS level 3 or 4 for eating were identified as being at risk for being affected by this practice. Dining area observations were conducted by the Director of Nursing to identify optimal seating arrangements that promote individualized attention to these residents who require extensive to total assist with eating. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:**	
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 observation, interview, and record review the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, for 1 of 23	4 136	On 6/14/16 the Administrator and Director of Nursing provided in-service training to staff regarding the need to provide individualized 1:1 attention to enhance the dining experience for those residents requiring extensive to total assist. All re-education regarding the need to provide 1:1 attention to enhance the dining experience will be completed by 7/5/2016. **How the corrective action will be monitored to ensure the deficient practice will not recur:** A Focus Audit was developed to address dignified feeding of nutritionally dependent residents. This Focus Audit will be used as a structured format when dining area observations are conducted. Dining area observations will be conducted by clinical staff weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. Audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends, and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	

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4 136	Continued From page 5 residents surveyed in the Stage 2 sample. Finding includes: [redacted]	4 136	**4 136: 11-94.1-30 Resident Care** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Per interview with direct care staff, the resident has a longstanding history of not wanting to use the neck pillow and, for this reason, the neck pillow had not been in use for some time. Upon interview with resident, [redacted] reported that the neck pillow does not help [redacted] does not like it, and [redacted] does not want to wear it. [redacted] reported that the small pillow that is used behind [redacted] back helps [redacted] a little bit, and [redacted] wants to continue using it. On 5/26/2016, the MDS Coordinator immediately amended the care plan to discontinue this approach . **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this practice . The IDT reviewed all residents and currently there are no other residents who require positioning devices for meals. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** On 6/14/16 the Administrator and Director of Nursing provided in-service training to staff regarding the importance of reporting when there is a suspected need to adjust the resident's care plan; the care that is provided should correlate with what is on the care plan. Education provided regarding the ability to report changes by using the NEW ALERT tab in the EMR which would then trigger investigation into the possible need (continued)	7/5/2016

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4 136	Continued From page 6 [redacted]	4 136	(continued) for care plan update and then a change in the care plan if needed . All re-education regarding the need to ensure the care plan accurately reflects that care that is provided will be completed by 7/5/2016 **How the corrective action will be monitored to ensure the deficient practice will not recur:** A Focus Audit was developed to ensure that resident care needs are accurately reflected on the resident's care plan. This Focus Audit will be used as a structured format when observing and interviewing staff and residents regarding the resident's care. Audits will be conducted by the MDS Coordinators (or designee) weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters . Audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends, and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on observation, family interview, record review and staff interview, the facility failed to	4 149	**4 149: 11-94.1-39(b) Nursing Services** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** [redacted] Activities Director and Social Services Director met with resident #30 [redacted] Sleep assessment completed; [redacted]	7/5/2016

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4 149	Continued From page 7 develop a comprehensive care plan that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 23 residents in the Stage 2 sample (Resident #30). Finding includes: [redacted]	4 149	(continued) [redacted] the MDS Coordinator developed a care plan [redacted] **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 6/17/2016, Director of Nursing reviewed care plans for all residents receiving sedatives / hypnotics for an appropriate care plan that addresses issues inclusive of non-pharmacological interventions. Care plans in place and appropriate. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** On admission, quarterly with the MDS Schedule, and with any significant change in condition, insomnia and the use of sedatives / hypnotics will be reviewed and care plans revised accordingly. **How the corrective action will be monitored to ensure the deficient practice will not recur:** A Focus Audit was developed as a structured format to audit appropriate care planning of psychopharmacological medication (including sedatives / hypnotics) to resident conditions. The Social Services Director, MDS Coordinator or designee will perform this audit weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters . Audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends, and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	
4 159	11-94.1-41(a) Storage and handling of food	4 159		

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4 159	Continued From page 8 (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 proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation and interview the facility failed to store food under sanitary conditions. Finding includes: On 05/24/2016 at 7:28 AM during the initial kitchen tour observed that there was foil covering food items dated 05/20/16 and use by 5/25/16. The food items were 2 plates of tossed salad, several individual yogurt containers, a large can of olives with the jagged top of the can used as a cover, and a quart sized container of mandarin oranges. When queried the kitchen staff (KS), if the dates on the foil applied to all the food items, KS#1 immediately tossed out all of the food items except for the yogurt containers with expiration dates still ok.	4 159	**4 159: 11-94.1-41(a) Storage and handling of food** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 5/24/16, all food items that were not properly labeled but covered with foil were disposed of by the kitchen staff member. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected but there were no adverse outcomes. On 5/24/16, the General Service Director assessed all food storage areas to ensure that all food items were properly stored in a sanitary manner; all food storage areas were found to have food stored appropriately. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** On 6/21/16, in service training will be provided by the General Services Director to dietary staff regarding the proper storage / labeling of food. All re-education regarding the proper storage / labeling of food will be completed by 7/5/2016. Starting 6/22/16, after each meal, the Diet Aide will audit the area items were found to assure that all foods are individually covered, properly labeled and dated. **How the corrective action will be monitored to ensure the deficient practice will not recur:** (continued)	7/5/2016
4 185	11-94.1-46(b) Pharmaceutical services (b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and director of nursing that:	4 185		

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4 185	Continued From page 9 (1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs; (2) Is reviewed at least every two years and revised as necessary to keep abreast of current developments in overall drug usage; and (3) Has a drug recall procedure that can be readily implemented. This Statute is not met as evidenced by: Based on record review, pharmacy review and staff interview, the facility failed to provide adequate monitoring, gradual dose reduction or indications for use for two [redacted] meds for 1 of 10 residents in the Stage 2 survey. (Resident #30) Finding includes: [redacted]	4 185	(continued) A Focus Audit was developed as a structured format to audit proper food storage. The General Services Director (or designee) will perform this audit weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. Audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends, and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement. **4 185: 11-94.1-46(b) Pharmaceutical services** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 5/26/16, the RN Charge Nurse contacted Resident #30's physician to review current use of the [redacted] medications, [redacted] After discussion of resident's condition, physician ordered to discontinue PRN [redacted] Physician decided to make no changes to the [redacted] as resident continues with episodes of [redacted] **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. By 7/5/2016 all residents receiving [redacted] medications will be reviewed to ensure the drug's use is necessary and there is adequate monitoring, gradual dose reduction or indications for use. (continued)	7/5/2016

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4 185	Continued From page 10 [redacted]	4 185	(continued) **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** When a [redacted] medication is prescribed, the MDS Coordinator with the Social Services Director will ensure that the resident's plan of care specifies non-drug interventions addressing the [redacted] issue. On 6/14/16 the Administrator and Director of Nursing provided in-service training to all nursing staff regarding the need for resident's drug regimen to be free from unnecessary drugs including the use of non-drug interventions. All re-education regarding the need for resident's drug regimen to be free from unnecessary drugs including the use of non-drug interventions will be completed by 7/5/2016. **How the corrective action will be monitored to ensure the deficient practice will not recur:** A Focus Audit was developed as a structured format to audit necessary and appropriate use of [redacted] medication (including [redacted]. The Social Services Director, MDS Coordinator or designee will perform audits weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. Audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends, and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	
4 199	11-94.1-46(p) Pharmaceutical services (p) When appropriateness of drugs or dosage of drugs as ordered are questioned by the pharmacist or licensed nurse, the licensed nurse or the pharmacist shall consult the physician, and a record of the consultation shall be made available to the administrator of the facility or director of nursing. This Statute is not met as evidenced by: Based on record review, staff interviews, and	4 199		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CE	45-090 NAMOKU ST KANEOHE, HI 96744

(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
4 199	Continued From page 11 pharmacy review the facility failed to conduct a drug gradual dose reduction (GDR) for 1 of 23 residents in the Stage 2 sample. Finding includes: [redacted]	4 199	**4 199: 11-94.1-46(p) Pharmaceutical services** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 5/26/16, the Charge Nurse contacted Resident #30's physician and reviewed pharmacy consultant's recommendations. An order was then obtained to discontinue PRN use of [redacted] **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. Director of Nursing and Health Information Coordinator reviewed all pharmacy consultants' recommendations to ensure that each resident's physician responded to the recommendation. By 6/16/16, all recommendations were addressed by the physicians. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** The pharmacy consultant will email her recommendations directly to the Director of Nursing and Health Information Manager. Upon receiving the recommendations, the Health Information Coordinator will fax each recommendation to the appropriate physician for review. The Health Information Coordinator will maintain a copy of the faxed recommendation. If the physician does not respond to the recommendation within 7 days, the Health Information Coordinator will notify the Director of Nursing. The Director of Nursing will contact the physician to inquire on the status of the pharmacist's recommendation.	7/5/2016
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by:	4 203		

If the physician does not respond within 3 days, the Director of Nursing will immediately notify the Medical Director for appropriate follow-up. (continued)

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4 203	Continued From page 12 Based on observations, interviews, and policy review the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Findings includes: [redacted]	4 203	(continued) **How the corrective action will be monitored to ensure the deficient practice will not recur:** A Focus Audit was developed as a structured format to audit follow through on pharmacy recommendations. The Director of Nursing (or designee) will perform this audit weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters . Audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends, and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement. **4 203: 11-94.1-53(a) Infection control** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 5/27/16, the Director of Nursing re-educated CN #1 on the facility's infection control policy and procedure including proper hand hygiene and handwashing during wound care to prevent and control infectious diseases. On 5/26/16, the Director of Nursing re-educated the CNA #1 on the facility's infection control policies and procedures regarding proper hand hygiene. On 5/24/16, the Director of Nursing promptly removed and disposed of the two plastic bedpans and the one urinal. On 5/24/16, the Director of Nursing promptly labeled the two plastic bottles and the one body lotion with the appropriate resident's name. (continued)	7/5/2016

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4 203	Continued From page 13 [redacted]	4 203	(continued) **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this practice. On 5/24/16, the Director of Nursing inspected each resident's room and bathroom to ensure that each resident's personal care items were properly labeled and that all bed pans and urinals were properly stored. No other personal care items requiring labeling were found. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** On 6/17/2016, the Administrator and DON reviewed the process for distribution of resident personal care items. The UC will label each resident's personal care item prior to them being stocked in the resident room. On 5/27/16, the Director of Nursing re-educated licensed nurses on the facility's infection control policies and procedures including including proper hand hygiene and handwashing during wound care to prevent and control infectious diseases. On 5/27/16, the Director of Nursing and Administrator re-educated the nursing staff on the facility's infection control policies and procedures regarding proper hand hygiene. All re-education regarding infection control as related to wound care, hand hygiene, storage of urinals / bed pans and labeling of personal care items will be completed by 7/5/2016. (continued)	

Hawaii Dept. of Health, Office of Health Care Assuranc

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4 203	Continued From page 14 [redacted]	4 203	(continued) **How the corrective action will be monitored to ensure the deficient practice will not recur:** Focus Audits were developed as a structured format to address hand hygiene during wound care and feeding and the proper labeling and storage of personal care items. The Director of Nursing and Administrator (or designee) will perform this audit weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. Audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends, and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	