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
AMENDED POC	125007	A. BUILDING: ______ B. WING ______	10/14/2016

RECEIVED 2016 DEC -7 A 11:11 STATE OF HAWAII DOH-OHCA MEDICARE

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MAKUA - KAHULUI	472 KAULANA STREET KAHULUI, HI 96732

(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
4 000	11-94.1 Initial Comments A relicensure survey was conducted from October 11 to 14, 2016. The facility census at the time of entrance on the morning of 10/11/16 was 228 residents. The facility is licensed for 254 beds.	4 000	4 088, 1) & 2) We disagree with the assertion that we are, or were providing substandard care and actual harm and that the administration did not efficiently and effectively use its resources to address resident falls that resulted in injury. However, the following actions have been undertaken:	
4 088	11-94.1-16(a) Governing body and management (a) Each facility shall have an organized governing body, or designated persons functioning as the governing body, that has overall responsibility for the conduct of all activities. The facility shall maintain methods of administrative management that assure that the requirements of this section are met. This Statute is not met as evidenced by: Based on observation, interview, and policy review the facility failed to administer its resources effectively and efficiently to maintain the highest practicable physical, mental, and psychosocial well-being for each resident. Findings include: The survey team determined the facility was providing substandard quality of care and actual harm. 1) On 10/13/2016 at 9:36 AM in an interview with the DON and ADM regarding a falls committee to address the number of falls occurring at the facility since the last survey. The ADM shared falls are discussed at the Interdisciplinary Team meetings, case by case so the problems can be addressed immediately. In Quality Assurance meeting there is minimal discussion due to when falls happen discussion is done by IDT. IDT meets twice a week, QA meets only quarterly - interventions happen in IDT". The DON stated, "a couple of weeks ago we talked about it (Falls),	4 088	A consultant was hired to review our falls management and QA process. She was onsite 10/25 & 10/26/16. A new "huddle" process was initiated 11/4/16 wherein staff meet to discuss and investigate falls or elopements as soon as possible after the event. A progress note is made to document the discussion. Interventions, if identified, are implemented immediately. The care plan is reviewed, and updated if necessary, at the conclusion of the huddle. The Rehab Manager, who is an occupational therapist, has joined the IDT meeting twice weekly to contribute to in-depth discussion and analysis of falls. At its 11/2/16 meeting, the QA Committee chartered a Falls Management Process Improvement Project (PIP) team. This multi-disciplinary team first met on 11/14/16. They are charged with trending falls data, analyzing root causes, and recommending and implementing interventions. They are utilizing, among other materials, the Falls Management Program: A Quality Improvement Initiative for Nursing Facilities, from the CMS web site. The PIP Team reports to the QA Committee. *continued on next page*	10/26/16 11/4/16 & ongoing 11/8/16 & ongoing 11/14/16 & ongoing

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Connie Miller — TITLE: Administrator — (X6) DATE: 12/5/16

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4 088	Continued From page 1 we track QA indicators, we are below national levels, it goes up and down. We want to be below state levels. We saw trending in quality climbing above the state levels." When it was pointed out that the increase in fall rates based on the facility's fall summary log began in July 2016, where the number of falls estimated count was 58. The Administrator stated, "I agree the task force is late in starting". Regarding falls intervention the ADM stated "sometimes it doesn't always work, we tried everything and finally said that falls was an acceptable risk". 2) The administration did not efficiently and effectively use its resources to address resident falls that resulted in injury. Reference the following citations for more details: 11-94.1(30). Cross reference to 11-94.1(30). Cross reference to 11-94.1(39)(a). A Quality Assessment and Assurance interview was conducted with the Administrator on the morning of 10/14/16 at approximately 11:20 A.M. In reference to issues/problems, the Administrator reported that issues were addressed within each department by it's respective Department Head. The Department Head was responsible for monitoring their own processes. They brought reports (CASPER, survey findings, complaints, observations, etc.) and shared them with the QAA	4 088	4 088, 1) & 2), continued At its 11/2/16 meeting, the QA Committee finalized a QAPI Plan, voted to change its meeting process to be more focused on discussion of data and processes, determined to rename itself the QAPI Committee to acknowledge its expanded role, and to begin meeting monthly.	11/2/16 & ongoing

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4 088	Continued From page 2 Committee. The Administrator noted that the QAA Committee meets on a quarterly basis and information/data was being reported more than taking actions. She stated they were attempting to follow the Centers for Medicare and Medicaid (CMS) guidelines 12-Step Program for Quality Assurance and Performance Improvement (QAPI) program. The Administrator noted the facility was on Step 7. She described the program as a step by step guide to implementing QAPI. She noted the facility was systematically going through the 12 steps. In the end, the Administrator stated they would have process improvement plans in place and working towards that. In terms of projects, the Administrator noted, "We do have lots of projects but they're happening in departments. The departments then bring their progress and results to QAA Committee. In terms of the quality issues brought forth during the survey, the Administrator noted, "We just recently saw an uptick in falls." She noted the DON had just talked with her managers about a task force for falls. The next QAA meeting was scheduled for 11/2/16 when the DON would've reported about the falls/injuries. She stated, "It's not that improvements don't happen." The Administrator provided an example of a QAA project regarding their Maintenance Exercise Program (MEP), where the State Agency found deficient practice during the last survey. She reported that residents previously waited for long periods of time in the hall for the MEP. She reported they've worked on the wait times and it has drastically improved. In summary, the QAA Committee was aware of presenting issues (falls and elopements) which were presented to the committee. Several residents experienced actual harm based on the facility's lack of interventions and oversight of	4 088		

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4 088	Continued From page 3 residents who were at risk for harm/injury. Despite this knowledge, the QAA Committee failed to address the identified issues/problem to maintain the safety and well being of residents at high risk for injury/harm.	4 088	4 115: Neighborhood staff received inservice training by Nursing Supervisor and Shift Supervisors regarding residents' rights with focus on dignity as it pertains to stated resident's concern.	10/12/16 to 11/18/16
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 interviews, observation, and record review the facility failed to promote care for a resident in a manner that maintains or enhances the resident's dignity and respect in full recognition of his or her individuality for 1 of 54 residents in the Stage 2 sample. Finding includes:	4 115	Additional post-survey inservice was conducted with all nursing staff when Statement of Deficiencies was received. The citations were shared and discussed with nursing staff.	11/15/16 & ongoing 11/15/16 & ongoing

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4 115	Continued From page 4	4 115		11/21/16
			All Neighborhoods did a check of the call light system to ensure that residents' call lights are working properly and that residents are able to use them. If needed, call lights were changed to accommodate resident's functional limitations.	10/19/16 & ongoing
			Director of Nursing and Nursing Supervisors make daily rounds several times a day and are observing staff and resident communication. Individual concerns will be addressed immediately and staff are aware that corrective action can occur if expectations are not met.	11/21/16 & ongoing
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.	4 136	Social Service and Nursing Management will perform QA studies regarding customer satisfaction and present results at QAPI meeting.	11/28/16 & ongoing

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4 136	Continued From page 5 This Statute is not met as evidenced by: Based on observations, reviews of event reports, review of medical records, staff interviews, and facility policy review, the facility failed to ensure the safety of 11 residents reviewed for accidents and elopements during stage 2 of the QIS survey warranting an Immediate Jeopardy (IJ). Additionally, the facility failed to ensure appropriate monitoring of medications for 1 of 5 residents reviewed for unnecessary medication use. Findings include:	4 136		11/14/16 & ongoing

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4 136	Continued From page 7	4 136		

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HALE MAKUA - KAHULUI	472 KAULANA STREET KAHULUI, HI 96732

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4 136	Continued From page 21	4 136		

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4 136	Continued From page 22	4 136		

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4 136	Continued From page 23	4 136		

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4 136	Continued From page 24	4 136		

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4 136	Continued From page 25	4 136		

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4 136	Continued From page 26	4 136		

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4 136	Continued From page 27 An interview of the Administrator on the afternoon of 10/12/16 at approximately 2:15 P.M. regarding the issue of falls and their plans for prevention of further incidents and injuries revealed the facility did not have a falls committee nor were they implementing any preventive actions for accidents. The Administrator noted that falls data gets collected and reported at Quality Assessment and Assurance (QAA) Committee meetings which meets quarterly. The State Agency asked the QAA Committee's position on the number of falls and elopements, to which the Adminstrator reported the data was all that was reported. No plans/interventions were	4 136	Therefore, the number of falls and falls with major injury do not demonstrate an Immediate Jeopardy finding. HM is committed to the well being and safety of our residents. These comparisons to national averages show that with the population we serve, falls do occur, within and outside of nursing homes, despite best efforts and interventions. The statement that we were not implementing any preventive actions for accidents is blatently untrue, as evidenced by hundreds of interventions documented in care plans, CAA notes, clinical progress notes, event invesigations, CNA Resident Summaries, and IDT notes.	

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4 136	Continued From page 28	4 136		

implemented from the data provided to QAA. The Administrator further noted that Root Cause Analyses (RCA) were conducted on a case by case basis for falls. She reported they don't perform a RCA for all falls as it wasn't feasible.

An interview with the Director of Nursing (DON) and Administrator on the morning of 10/13/16 at approximately 9:30 A.M. found the facility utilized their Interdisciplinary Team (IDT) meetings to discuss falls and elopements. The IDT meets twice per week to discuss trends, which then gets reported to QAA Committee. The DON and Administrator reported they only recently saw an uptick in falls. They stated, "We are starting a falls committee." The DON reported that she had a preliminary meeting to determine who would participate in the falls committee and when they would meet. The State Agency asked whether the DON documented the meeting notes and she reported she did not keep notes of that meeting. The Committee was apparently supposed to meet on 10/13/16 but it was cancelled due to the survey team arriving. The Administrator noted that some residents experienced a lot of falls because they were declining in health.

She explained that some residents will continue to fall regardless of facility intervention. She further noted that her stance was to ensure the resident and/or their families were aware of the risks and benefits of the resident experiencing falls.

She described situations like those as an "acceptable risk". Despite the Administrator's stance on the issue, the residents reviewed during this survey

Provider's Plan of Correction:

Following survey we had a consultant review our falls program and have made changes as follows: — 10/26/16

Neighborhood Huddles are done at the time of every fall event. It is a highbred of our initial event report process. Huddles involve CNAs, LNs and other disciplines present on the neighborhood at the time of incident. A progress note is made to document the discussion. Interventions, if identified, are implemented immediately. The care plan is reviewed, and updated if necessary, at the conclusion of the huddle. Information is communicated to all shifts. — 11/4/16 & ongoing

After the huddle and before IDT review, the Neighborhood Manager or designee continues to assess for root cause, evaluate effectiveness of interventions and make any changes as needed. — 11/4/16 & ongoing

The IDT reviews the falls event report, neighborhood huddle clinical note, any other clinical note associated to fall, interventions that were implemented, the investigation fall form, in addition to other criteria to analyze root cause and to ensure that appropriate interventions have been implemented. — 11/4/16 & ongoing

The Rehab Manager, who is an occupational therapist, has joined the IDT meeting twice weekly to contribute to in-depth discussion and analysis of falls. — 11/8/16 & ongoing

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4 136	Continued From page 29 did not have documentation to demonstrate the "acceptable risk" she was referring to.	4 136	On 10/13/16 the process was started to review care plans of residents identified at high risk for safety issues (falls and elopement) and to revise/update as appropriate.	10/13/16 & ongoing
			Post survey inservice was done with all Licensed Nurses and Head CNAs, with emphasis on timely revisions of Nursing and CNA care plans.	11/14/16 & ongoing
			At its 11/2/16 meeting, the QA Committee chartered a Falls Management Process Improvement Project (PIP) team. This multi-disciplinary team first met on 11/14/16. They are charged with trending falls data, analyzing root causes, and recommending and implementing interventions. They are utilizing, among other materials, the Falls Management Program: A Quality Improvement Initiative for Nursing Facilities, from the CMS web site. The PIP Team reports to the QA Committee.	11/14/16 & ongoing
			At its 11/2/16 meeting, the QA Committee finalized a QAPI Plan, voted to change its meeting process to be more focused on discussion of data and processes, determined to rename itself the QAPI Committee to acknowledge its expanded role, and to begin meeting monthly.	11/2/16 & ongoing
			To ensure that standards are met, care plans will be reviewed during resident care conference by IDT and prn by neighborhood licensed nurses.	11/14/16 & ongoing
			Resident Care Coordinator Supervisor and Nursing Administration will perform QA studies monthly until standard is met, then every 6 months for 1 year.	11/28/16 & ongoing

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4 136	Continued From page 30	4 136		11/15/16 to 11/21/16 10/14/16

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4 136	Continued From page 31	4 136	4 136, 16) continued: Acting Neighborhood manager was educated by Nursing Supervisor on 10/14/16 regarding implementation of weekly behavior monitoring.	10/14/16
			Weekly behavior monitoring was initiated for all residents with identified behavior and/or on psychotropic medication. Neighborhood managers and LNs received education regarding our policy and procedure on behavior monitoring and standards of practice associated with psychotropic medication, to ensure that all residents with behaviors and on psychotropic medications are being monitored appropriately.	11/16/16 & ongoing
			To ensure that standards are met, care plans will be reviewed during resident care conference by IDT and prn by Neighborhood Managers and Licensed Nurses.	11/14/16 & ongoing
			Resident Care Coordinator Supervisor and Nursing Administration will perform QA studies monthly until standard is met, then every 6 months for 1 year.	11/28/16 & ongoing

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4 136	Continued From page 32	4 136		
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on resident, family, and staff interviews; observations, and record reviews the facility failed to ensure sufficient nursing staff are available to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Findings Include: Cross Reference to 11-94.1(30)	4 148	4 148: We schedule staff to accommodate our census and acuity. We don't have control over unexpected call-ins, but it is always our first priority to replace staff and add staff if necessary to meet the needs of the residents in our facility. Our highest purpose is to ensure that the residents attain or maintain their highest practicable physical, mental and psychosocial status as determined by their assessments and individual plans of care. According to Nursing Home Compare, Hale Makua-Kahului has more CNA hours per resident day than the state average and the national average. We are 4 minutes below the national average for RN hours, but our LPN hours per resident per day are equal to the national average and more than double the state average. We are rated 4 stars (above average) for staffing levels. *continued on next page*	

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4 148	Continued From page 33 In an interview with the Director of Nursing, she stated that currently they are tracking falls but the Quality Assurance (QA) committee had not considered falls as a project at present. In a staff interview regarding staffing and if the residents get the care they need in a timely manner, LN#3 stated "in my honest opinion no, but they finish". She states the residents don't tend to complain but they often have to wait. Stated that "I feel like if I had my strong team with me (primary) then yes. It was harder if not the regular team so they would have to have more oversight and have my CNA go check the floaters work which would take away from the time they have to care for the residents.	4 148	During survey, LN #3 informed DON that surveyor asked her about staffing. She did not elaborate as to what she told the surveyor except to say that it made a difference when primary staff of the neighborhood was working. Nursing Administration agrees that primary staff make a difference. We do schedule primary staff on all neighborhoods. There are exceptions when it comes to replacing staff during planned and unplanned absences.	

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4 148	Continued From page 34 In summary of resident, family, and staff	4 148		11/21/16 11/22/16 10/26/16 & 11/21/16

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4 148	Continued From page 35 interviews; along with record reviews, the facility failed to ensure residents were receiving services in a manner to attain or maintain their highest level of functioning and safety.	4 148	4 418, continued: On the evening of 10/13/16 we added staff to all shifts on the Ilima and West neighborhood as part of our abatement plan. They are designated to supervise residents identified as high risk for falls. This changes remain in place while we fully analyze our current staff needs in relationship to resident safety and implement appropriate changes.	10/13/16 & ongoing
			On 10/13/16 the process was started to review care plans of residents identified at high risk for safety issues (falls and elopement) and to revise/update as appropriate.	10/13/16 & ongoing
			Nursing Administration will continue to closely collaborate with neighborhood managers to ensure each neighborhood has sufficient staff to meet residents' care needs.	10/13/16 & ongoing
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 observation, record review, interviews, and the facility failed to periodically review and revise care plans for 11 of 54 residents in the Stage 2 sample. Finding includes: 1) Cross reference to 11-94.1(30) for	4 175	4 175: We are filing an Informal Dispute Resolution and disagree with the assertion that the facility failed to periodically review and revise care plans. Some documentation cited as lacking or missing has been copied and sent to the State with the dispute. However, the following actions have been undertaken:	
			Nursing Administration did a record review for all residents cited.	11/14/16 & ongoing

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4 175	Continued From page 36	4 175		

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4 175	Continued From page 37	4 175		

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4 175	Continued From page 40	4 175		

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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
4 175	Continued From page 41	4 175		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125007	A. BUILDING: ______ B. WING ______	10/14/2016

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4 175	Continued From page 42	4 175		

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4 175	Continued From page 43	4 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 10/14/2016

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4 175	Continued From page 44	4 175		

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4 175	Continued From page 45	4 175		

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4 175	Continued From page 46	4 175		

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4 175	Continued From page 47	4 175		
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: Based on observation, policy review, and interview the facility failed to provide a safe and	4 203	4 175: On 10/13/16 the process was started to review care plans of residents identified at high risk for safety issues (falls and elopement) and to revise/ update as appropriate.	10/13/16 & ongoing
			Post survey inservice was done with all Licensed Nurses and Head CNAs with emphasis on timely revisions of Nursing and CNA care plans.	11/14/16 & ongoing
			To ensure that standards are met, care plans will be reviewed during resident care conference by IDT and prn by neighborhood Licensed Nurses. *continued on next page*	11/14/16 & ongoing

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4 203	Continued From page 48 sanitary environment to help prevent the development and transmission of disease and infection for one resident in the Stage 2 sample.	4 203	4 175 continued: Resident Care Coordinator Supervisor and Nursing Administration will perform QA studies monthly until standard met, then every 6 months for 1 year.	11/28/16 & ongoing
	Finding includes:		4 203: Although this was not identified by surveyors in the exit interview, on 10/14/16, LN#5 was very forthcoming with sharing the deficient practice as mentioned in the citation with DON. LN#5 was provided special education by DON regarding infection control standards. Emphasized sanitizing/washing hands prior to obtaining a new pair of gloves from a receptacle and donning it.	10/14/16
			DON observed LN#5 doing a dressing change on 11/17/16 to ensure that she is following and maintaining infection control standards. Before starting, LN washed her hands, dried them and then donned a clean pair of gloves. She cleaned the resident's wound and removed her gloves. She then sanitized her hands, donned a clean pair of gloves and applied boarded foam. LN#5 met standard.	11/17/16
			Post-survey inservicing of Licensed Nurses and Certified Nursing Assistants was conducted regarding the importance of following infection control standards, focusing on hand hygiene opportunities, proper doffing/donning techniques when using gloves. Infection control techniques will also be reiterated during proficiency skill review for LNs and CNAs.	11/14/16
4 243	11-94.1-64(a) Engineering and maintenance	4 243	Neighborhood Managers and Shift Supervisors will perform an initial QA audit to ensure that LNs and CNAs are maintaining infection control standards. Audits will continue monthly until standard is met.	11/21/16 & ongoing

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4 243	Continued From page 49 (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Finding includes: 1) During a tour of the facility's rehabilitation unit on 10/13/2016 at 1:49 PM, observed an Estim and Ultrasound combo machine which the Rehabilitation Supervisor stated was for residents to use to stimulate resident muscles. The label on the Estim machine on service date showed last inspected 1/2014 and next inspection date 1/2015. The Rehab Supervisor shared the machine was used a month ago on a resident. The Rehab Supervisor could not confirm the reason for the expired date of servicing on the machine. On 10/18/2016 the Administrator sent a message that stated, "the machine was due for calibration".	4 243	4 243, 1): This was not mentioned by surveyors in the exit interview. Administrator was made aware of need for calibration of Estim machine on 10/18/16 through phone call from Medicare Certification Officer, and immediately removed the machine from the rehab gym to prevent further use.	10/18/16
			Annual preventive maintenance, safety check, and calibration completed by Island Biomed on 10/28/16. Equipment returned to rehab gym on 11/2/16.	10/28/16
			Estim machine was added to BigFoot software for tracking. BigFoot software will automatically generate a work order for preventive maintenance on an annual basis.	10/18/16
			Clinical Operations Area Director of contracted rehab provider conducted an inventory of all equipment in rehab gym and provided to Hale Makua Equipment Coordinator to ensure that preventive maintenance is documented and scheduled in BigFoot software for all equipment.	11/15/16
				10/12/16

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4 243	Continued From page 50	4 243		10/14/16 & ongoing
			LN#3 went on vacation before survey results received on 11/14/16. LN#3 will receive education from Nursing Supervisor upon her return from vacation, regarding timely follow-up and replacement of resident's call light if not functioning properly, in addition to resident safety.	11/24/16
			All neighborhoods did a check of the call light system to assure that resident call lights are working properly, that they are able to use them and if needed, call lights were changed to accommodate resident's functional limitations.	10/19/16 & ongoing
			Activities Department and Nursing will perform monthly QA studies on call light functionality and appropriateness for resident until standard met, then every 6 months for one year.	11/28/16 & ongoing