Hawaii Dept. of Health, Office of Healt are Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125065	A. BUILDING: ___ B. WING ___	09/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HILO REHABILITATION & NURSING C	563 KAUMANA DRIVE HILO, HI 96720

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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
4 000	11-94.1 Initial Comments A State re-licensure survey was conducted by the State Agency from 9/13/16 to 9/16/16. The resident census on entrance was 54 residents.	4 000		
4 002	11-94.1-2 Definitions As used in this chapter: "Activities professional" or "qualified therapeutic recreational specialist" means: (1) A qualified professional who has two years of experience in a social or recreational program within the last five years, one of which was full-time in a resident activities program in a health care setting; (2) An occupational therapist or occupational therapy assistant; (3) A person who has completed a training course approved by the department; or (4) A person who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990. This Statute is not met as evidenced by: Based on record review and staff interview, the facility did not ensure that the activities program must be directed by a qualified professional who	4 002	4 002 11-94. 1-2 Definitions 1. Corrective Action for Resident in Sample: Inservice on 4 002 with staff will occur with signatures acknowledging of an Activity Coordinator qualifications & requirements of job title. 2. Identification of other Residents Having the Potential of Being Affected: Activities program is consulted daily by occupational therapist with appropriate credentials to meet regulatory requirements. Documentation of daily meetings and discussion is maintained by AD/OT. 3. Corrective Action/Systemic Changes: Activities Program Director is currently enrolled in classes for regulatory requirements to be "Activities Professional". 4. Monitoring of Corrective Actions to Ensure No Recurrence: Will be monitored in the QA Report quarterly until AD is accredited.	10/17/16

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/31/16

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4 002	Continued From page 1 is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. Findings include: Record review of the current Activity Director's (AD) resume and an interview with the AD was done on 09/16/2016 at 9:20 A.M. The AD was asked what qualified her to be the facility's AD. The AD said she started in her position on or about July 18th or 19th, 2016 and, "I need some certification to be medical." She said because she was under the Nursing Home Administrator's (NHA) direction, "and she (NHA) has the RN degree, I don't," the AD thought she was qualified to be the AD. The federal regulatory requirement was read to the AD and thereafter, she verified she currently is not qualified to be the AD. Further review found however, this AD had signed her job description (JD) on 8/4/2016, attesting to the qualifications/educational experience stated within it on page 2, which included the federal regulatory requirements read to her by the State Agency surveyor (SA) during her interview. In addition, the job description (JD) which the AD signed was developed by the prior management company; thus, it is not Legacy Hilo Rehabilitation & Nursing Center's JD for the AD position either.	4 002	4 002 11-94. 1-2 Definitions 1. Corrective Action for Resident in Sample: Inservice on 4 002 with staff will occur with signatures acknowledging of an Activity Coordinator qualifications & requirements of job title. 2. Identification of other Residents Having the Potential of Being Affected: Activities program is consulted daily by occupational therapist with appropriate credentials to meet regulatory requirements. Documentation of daily meetings and discussion is maintained by AD/OT. 3. Corrective Action/Systemic Changes: Activities Program Director is currently enrolled in classes for regulatory requirements to be "Activities Professional". 4. Monitoring of Corrective Actions to Ensure No Recurrence: Will be monitored in the QA Report quarterly until AD is accredited.	10/17/16

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4 002	Continued From page 2 During a discussion with the NHA who thought the AD requirements were based on the State regulatory requirements for "activities professional," she was informed if the federal requirements were more stringent for a Medicare certified facility, the SA will cite to that. The NHA nodded and said she will need to get her current AD qualified.	4 002	4 002 Qualifications of Activity Professional See Pages 1, 2	10/17/16
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 observations, record review, interviews and review of facility policies, the facility failed to maintain a quality assessment and assurance (QA&A) committee that has overrall responsibility for the conduct of all activities and failed to maintain methods of administrative management to assure the requirements are met, including a physician designated by the facility and demonstrating active participation in the facility's QA&A program. In addition, the QA&A committee did not have a quality assurance program that showed specific standards for quality of care and outcomes, nor have documentation to identify and show the study and improvement of processes to better resident care services and outcomes, or to prevent/decrease problems identified with respect to which quality assessment and assurance activities have been necessary to correct identified quality	4 088	4 088 11-9431-16(a) Governing body & management 1. Corrective Action for Resident in Sample: The DON and NHA met with the staff involved with QA and discussed the facility policy infraction, in regards to maintaining a quality assessment and assurance committee consisting of a physician designated by the facility and demonstrating active participation in the facility's QA&A. Emphasis is on the committee having specific standards for quality of care and outcomes, documentation to show the study and improvement of processes to better resident care services and outcomes to prevent/decrease problems identified with respect to which quality assessment and assurance activities have been necessary to correct identified quality deficiencies. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the licensed staff involved, daily, weekly and at random, to ensure compliance of proper standards for quality of care and outcomes. Effective 10-17-2016, Ms. Elizabeth Preston, APRN and Dr. Norman Goody joined Legacy of Hilo and will participate directly with QA to prevent/decrease problems identified with respect to quality assessment an assurance and as necessary to correct deficiencies.	10/17/16

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4 088	Continued From page 3 deficiencies. Findings include: During an interview with the NHA and DON on 09/16/2016 at 11:28 A.M., they were asked to describe the facility's QA&A program and what has been identified as performance improvement processes or measures. The DON initially stated she "goes off of CMS's indicators," such as pain, falls, skin and weight, nutrition, infections, etc. Upon query as to how then their resident care policies and procedures outlined a systematic process for the care of residents with areas such as falls, dementia, weight loss, etc., the DON's response was they followed the nursing assessment criteria of identifying it, observing it and implementing it and evaluating it based on resident outcome. However, a review of the resident care policy found the facility produced policies which belonged to another company, which were for Care Planning for Residents and for Standard Precautions, as evidenced by the policy titles. The facility did not have their own policies. Cross-reference to F279, F280. The SA also asked the NHA and DON how their QA & A committee monitored for consistent development and implementation of their policies and procedures for residents specific to falls in the facility and for those residents with recurrent falls. The DON stated the incident reports were given to her and at their daily stand up meeting, they become aware of who has fallen. She said then the CNAs huddle and check the veracity of the incident reports and then they look at other causal factors. She explained the falls were placed on a calendar with the time of the falls and she looked for the frequency and pattern of falls and causal factors. The DON was asked if she	4 088	Continued from Page 3 3. <u>Corrective Action /Systemic Changes:</u> All licensed staff meeting was conducted to review the facility QA process with the emphasis on specific standards for quality of care and outcomes, documentation of the study and improvement of processes that better resident care services. Participation by all members of the committee will be monitored to ensure compliance and to ensure no recurrence of the infraction. 4. <u>Monitoring of Corrective Actions to Ensure No Recurrence:</u> The DON/designee will coordinate with APRN and MD reviews to improve quality of care in areas such as Safety, Dining, Infection Control, Falls to achieve decrease in fall rates. Psychotropic Medication use, Pain, Skin and Weights (Nutrition at Risk). Data analysis, reviews of trends and patterns as well as audits of committee meetings and minutes will be done weekly, monthly and at random to ensure facility compliance with QAPI. The results on the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. Goal will be 2nd Quarter 90% compliance & 3rd Quarter 100% compliance.	10/17/16

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4 088	Continued From page 4 had documentation for this and replied the charge nurses documented it and that they do root cause analysis with their falls committee. Cross-reference to F323. When the NHA and DON were asked how their QA & A committee has provided monitoring and oversight for the care and services for residents with falls and the care plan process, as it was one of the areas of concern during the survey, the DON stated for the care plans, with each intervention, the care plans "are updated. I'm following up, we have a lot of new nurses we're working with." She also said "staffing vigilance as process--as our census has grown, our staffing has grown, and that has decreased the number of falls to date." However, the DON stated she "has no trending," for the SA to see. Yet, during the meeting, the DON said she did have a QA falls binder and stepped out of the meeting to look for the falls QA binder. At 11:45 A.M., upon her return to the meeting, she said she could not find the falls binder which had all of her QA falls material in it. Cross-reference to F278, F279, F280, F281. In addition, the NHA and DON were asked if they had identified issues with staffing and resident dining. The SA said dining observations found periods of time when there was no staff in the dining room and residents were waiting, and some residents needed full assistance to eat but were not provided with it. The DON replied, "We need more carts. It will look less chaotic and they'll be more individuals assisting. Right now I have meals being wheeled in and 2 carts, so I need to have more staff to feed." The DON was asked about the RNA dining program and how the program was being implemented and monitored. She stated, "I'll be observing and	4 088	4 088 11-9431-16(a) Governing body & management 1. Corrective Action for Resident in Sample: The DON and NHA met with the staff involved with QA and discussed the facility policy infraction, in regards to maintaining a quality assessment and assurance committee consisting of a physician designated by the facility and demonstrating active participation in the facility's QA&A. Emphasis is on the committee having specific standards for quality of care and outcomes, documentation to show the study and improvement of processes to better resident care services and outcomes to prevent/decrease problems identified with respect to which quality assessment and assurance activities have been necessary to correct identified quality deficiencies. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the licensed staff involved, daily, weekly and at random, to ensure compliance of proper standards for quality of care and outcomes. Effective 10-17-2016, Ms. Elizabeth Preston, APRN and Dr. Norman Goody joined Legacy of Hilo and will participate directly with QA to prevent/decrease problems identified with respect to quality assessment an assurance and as necessary to correct deficiencies. 3. Corrective Action /Systemic Changes: All licensed staff meeting was conducted to review the facility QA process with the emphasis on specific standards for quality of care and outcomes, documentation of the study and improvement of processes that better resident care services. Participation by all members of the committee will be monitored to ensure compliance and to ensure no recurrence of the infraction. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee will coordinate with APRN and MD reviews to improve quality of care in areas such as Safety, Dining, Infection Control, Falls to achieve decrease in fall rates. Psychotropic Medication use, Pain, Skin and Weights (Nutrition at Risk). Data analysis, reviews of trends and patterns as well as audits of committee meetings and minutes will be done weekly, monthly and at random to ensure facility compliance with QAPI. The results on the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. Goal will be 2nd Quarter 90% compliance & 3rd Quarter 100% compliance.	10/17/16

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Continued From page 5

checking with (RNA Nurse) to see if the resident is increasing their level of participation with self feeding." Then she was asked, what if the resident had weight loss, and her response was, "Then we have to re-evaluate what we're doing and get the dietitian to help me." She stated the Nutrition at Risk committee meets weekly and they have identified those residents and they "do a new assessment and the monitoring of it and we track what's happening with the individual." For a resident who has had significant weight loss, the DON said documentation would be found in the PCC (their electronic health record system) and "it's under nutrition risk," which tracks the resident's weights.

Related to facility staffing concerns and with so many new hire nurses, they were asked how the QA&A committee may have identified any quality deficiency areas related to the care of residents as a means for improvement, including the tools used to monitor that residents are getting the provision of care and services in some of the identified areas such as fall prevention, care planning, dining service and assistance, weight loss monitoring, etc. The DON stated it was done by providing education, whether of the staff or educating families, monthly inservices and by doing "daily huddles" where they discussed what was going on with individuals and residents and the separate shifts.

As to the staffing concerns, the DON said, "Some family members came to (the NHA) and said that I'm glad you have more staff." The DON said, "I haven't started implementing them, but now that we have case managers, I do have rounds and checklists to validate that. I don't have anything at this point, other than my word. I go in and check on the residents too. "For an identified

4 088 11-9431-16(a) Governing body & management

1. Corrective Action for Resident in Sample:
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4 088	Continued From page 6 problem, the NHA said that some people say they "need more rehab." The DON said also that the food served was cold on occasion, with some residents wanting more ethnic dishes and more avocados. "You're right I haven't written it down," was the response to the SA. Cross-reference to F353. They were asked if they could provide the SA with any other QA & A activities/programs they have implemented for process improvement. Their collective response was that they just got a skin nurse and the other care manager is a wound certified nurse. On 09/16/2016 at 12:44 P.M., Staff #2 brought the QA falls binder which she said she got from the DON to give to a surveyor. Staff #2 confirmed this is the only binder of falls and she had worked on alphabetizing all of the resident fall related incident reports. Although the DON stated during the interview they have had a decrease in the number of falls by having had increased staff, the last fall meeting of 9/7/16 included signatures of four licensed staff plus the DON and the topics of discussion included implementing fall mats for two residents, possibly moving one resident to a closer room or add a roommate and implementing a "fall checklist. "There was no other data to indicate how the	4 088	4 088 11-9431-16(a) Governing body & management 1. Corrective Action for Resident in Sample: The DON and NHA met with the staff involved with QA and discussed the facility policy infraction, in regards to maintaining a quality assessment and assurance committee consisting of a physician designated by the facility and demonstrating active participation in the facility's QA&A. Emphasis is on the committee having specific standards for quality of care and outcomes, documentation to show the study and improvement of processes to better resident care services and outcomes to prevent/decrease problems identified with respect to which quality assessment and assurance activities have been necessary to correct identified quality deficiencies. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the licensed staff involved, daily, weekly and at random, to ensure compliance of proper standards for quality of care and outcomes. Effective 10-17-2016, Ms. Elizabeth Preston, APRN and Dr. Norman Goody joined Legacy of Hilo and will participate directly with QA to prevent/decrease problems identified with respect to quality assessment an assurance and as necessary to correct deficiencies. 3. Corrective Action /Systemic Changes: All licensed staff meeting was conducted to review the facility QA process with the emphasis on specific standards for quality of care and outcomes, documentation of the study and improvement of processes that better resident care services. Participation by all members of the committee will be monitored to ensure compliance and to ensure no recurrence of the infraction. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee will coordinate with APRN and MD reviews to improve quality of care in areas such as Safety, Dining, Infection Control, Falls to achieve decrease in fall rates. Psychotropic Medication use, Pain, Skin and Weights (Nutrition at Risk). Data analysis, reviews of trends and patterns as well as audits of committee meetings and minutes will be done weekly, monthly and at random to ensure facility compliance with QAPI. The results on the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. Goal will be 2nd Quarter 90% compliance & 3rd Quarter 100% compliance.	10/17/16

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4 088	Continued From page 7 resident falls rate was being recorded, analyzed and how the facility was looking to specifically address it using quality metrics. Thus, with the collective review and findings in the areas of resident behavior and facility practice, quality of life and quality of care, resident assessment, dietary services, infection control, etc., and with no documentation to show how quality metrics or other clinical standards and practices were being implemented by the facility, demonstrated the fact that this facility does not have a current, on-going and intact quality assurance and management program.	4 088	4 088 11-9431-16(a) Governing body & management See Pages 3-7	10/17/16
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 observation, the facility failed to protect and promote the rights of each resident, including the right to a dignified existence and personal privacy, self-determination, and communication with and access to persons and services inside	4 115	4 115 11-94.1-27(4) Resident rights and facility Practices 1. Corrective Action for Resident in Sample: Education on 4 115 with staff will occur with signatures acknowledging understanding of infraction. Correct feeding techniques addressing distance of resident to meal tray has begun to enhance dining experience, promote dignity. 2. Identification of other Residents Having the Potential of Being Affected: Oher residents will be identified as requiring assist if having to reach forward to bend to reach meal tray. Distances will be adjusted per individual resident's proximity to meal tray. Dining room observations will be done daily.	10/17/16

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4 115	Continued From page 8 the facility for four residents of the 38 residents in the sample. Findings include:	4 115	Continued from Page 8 3. Corrective Action/Systemic Changes: Compliance with meal service assist will be documented daily as Dining room observations, discuss monthly at Dining Room committee meetings (3rd Tuesdays at 1400 hrs.) and maintained in a binder for reference. Orals checks of residents and appropriately fitting dentures will be done by unit nurse; documentation of findings will be noted in nursing. 4. Monitoring of Corrective Actions to Ensure No Recurrence: All residents will be set up with annual DDS appointments. The appointment schedule will be maintained by receptionist; she maintains transporter's agenda. Monitored by staff per meal time to ensure compliance. Results of this monitoring will be included in the quarterly QA meeting. Goal will be 90% for the 2nd quarter and 100% for the 3rd quarter.	10/17/16 10/17/16

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4 115	Continued From page 9	4 115	4 115 11-94.1-27(4) Resident rights and facility Practices 1. Corrective Action for Resident in Sample: Education on 4 115 with staff will occur with signatures acknowledging understanding of infraction. Correct feeding techniques addressing distance of resident to meal tray has begun to enhance dining experience, promote dignity. 2. Identification of other Residents Having the Potential of Being Affected: Oher residents will be identified as requiring assist if having to reach forward to bend to reach meal tray. Distances will be adjusted per individual resident's proximity to meal tray. Dining room observations will be done daily. 3. Corrective Action/Systemic Changes: Compliance with meal service assist will be documented daily as Dining room observations, discuss monthly at Dining Room committee meetings (3rd Tuesdays at 1400 hrs.) and maintained in a binder for reference. Orals checks of residents and appropriately fitting dentures will be done by unit nurse; documentation of findings will be noted in nursing. 4. Monitoring of Corrective Actions to Ensure No Recurrence: All residents will be set up with annual DDS appointments. The appointment schedule will be maintained by receptionist; she maintains transporter's agenda. Monitored by staff per meal time to ensure compliance. Results of this monitoring will be included in the quarterly QA meeting. Goal will be 90% for the 2nd quarter and 100% for the 3rd quarter.	10/17/16 10/17/16

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4 115	Continued From page 10	4 115	4 115 11-94.1-27(4) Resident rights and facility Practices 1. Corrective Action for Resident in Sample: Education on 4 115 with staff will occur with signatures acknowledging understanding of infraction. Correct feeding techniques addressing distance of resident to meal tray has begun to enhance dining experience, promote dignity. 2. Identification of other Residents Having the Potential of Being Affected: Oher residents will be identified as requiring assist if having to reach forward to bend to reach meal tray. Distances will be adjusted per individual resident's proximity to meal tray. Dining room observations will be done daily. 3. Corrective Action/Systemic Changes: Compliance with meal service assist will be documented daily as Dining room observations, discuss monthly at Dining Room committee meetings (3rd Tuesdays at 1400 hrs.) and maintained in a binder for reference. Orals checks of residents and appropriately fitting dentures will be done by unit nurse; documentation of findings will be noted in nursing. 4. Monitoring of Corrective Actions to Ensure No Recurrence: All residents will be set up with annual DDS appointments. The appointment schedule will be maintained by receptionist; she maintains transporter's agenda. Monitored by staff per meal time to ensure compliance. Results of this monitoring will be included in the quarterly QA meeting. Goal will be 90% for the 2nd quarter and 100% for the 3rd quarter.	10/17/16

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4 115	Continued From page 11 date of 09/07/2016.	4 115	4 115 11-94.1-27(4) Resident rights and facility Practices 1. Corrective Action for Resident in Sample: Education on 4 115 with staff will occur with signatures acknowledging understanding of infraction. Correct feeding techniques addressing distance of resident to meal tray has begun to enhance dining experience, promote dignity. 2. Identification of other Residents Having the Potential of Being Affected: Oher residents will be identified as requiring assist if having to reach forward to bend to reach meal tray. Distances will be adjusted per individual resident's proximity to meal tray. Dining room observations will be done daily. 3. Corrective Action/Systemic Changes: Compliance with meal service assist will be documented daily as Dining room observations, discuss monthly at Dining Room committee meetings (3rd Tuesdays at 1400 hrs.) and maintained in a binder for reference. Orals checks of residents and appropriately fitting dentures will be done by unit nurse; documentation of findings will be noted in nursing. 4. Monitoring of Corrective Actions to Ensure No Recurrence: All residents will be set up with annual DDS appointments. The appointment schedule will be maintained by receptionist; she maintains transporter's agenda. Monitored by staff per meal time to ensure compliance. Results of this monitoring will be included in the quarterly QA meeting. Goal will be 90% for the 2nd quarter and 100% for the 3rd quarter.	10/17/16 10/17/16

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4 115	Continued From page 12	4 115	4 115 11-94.1-27(4) Resident rights and facility Practices 1. Corrective Action for Resident in Sample: Education on 4 115 with staff will occur with signatures acknowledging understanding of infraction. Correct feeding techniques addressing distance of resident to meal tray has begun to enhance dining experience, promote dignity. 2. Identification of other Residents Having the Potential of Being Affected: Oher residents will be identified as requiring assist if having to reach forward to bend to reach meal tray. Distances will be adjusted per individual resident's proximity to meal tray. Dining room observations will be done daily. 3. Corrective Action/Systemic Changes: Compliance with meal service assist will be documented daily as Dining room observations, discuss monthly at Dining Room committee meetings (3rd Tuesdays at 1400 hrs.) and maintained in a binder for reference. Orals checks of residents and appropriately fitting dentures will be done by unit nurse; documentation of findings will be noted in nursing. 4. Monitoring of Corrective Actions to Ensure No Recurrence: All residents will be set up with annual DDS appointments. The appointment schedule will be maintained by receptionist; she maintains transporter's agenda. Monitored by staff per meal time to ensure compliance. Results of this monitoring will be included in the quarterly QA meeting. Goal will be 90% for the 2nd quarter and 100% for the 3rd quarter.	10/17/16

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4 115	Continued From page 13	4 115	4 115 11-94.1-27(4) Resident rights and facility Practices See Pages 9-13	10/17/16
	The staff members failed to accommodate R #72's need for placing the touch pad call light within reach.			10/17/16
4 130	11-94.1-29(a) Resident abuse, neglect, and misappropriation (a) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Statute is not met as evidenced by: Based on a review of the facility's policy and procedures and interview with staff members, the facility failed to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property, include	4 130	4 130 11-94.1-29(a) Resident abuse, neglect, and misappropriation 1. Corrective Action for Resident in Sample: Education inservice on 4 130 with staff will occur with signatures acknowledging understanding of Event Reporting of Incidents. 2. Identification of Other Residents Having the Potential of Being Affected: Unit nurses, nurse aides have been educated on event reporting for altercations as well as elopement; signatures acknowledge understanding. Other residents at risk for elopement/abuse will be identified through falls, safety, pain and nutrition at risk committee meetings as well as Grand rounds/Focus rounds done by NHA/designee, DON/designee, SDC, RSM.	

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4 130	Continued From page 14 reporting alleged violations to the State Agency. Finding includes: A review of "Event Reports" completed by the facility to the State Agency found reports were submitted from 11/24/15 through 7/19/16. The reports were related to falls; injuries of unknown origin; and alleged abuse by a family member. Upon request, the facility provided a copy of the "Abuse Prevention Program" on 9/16/16 at 8:34 A.M. A review of the facility's policy found in the section entitled "Reporting/Response" that the facility did not include reporting all alleged violations and all substantiated incidents to the State Agency. An interview was done with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on 9/16/16 at 12:45 P.M. The NHA and DON were agreeable that the the facility's policy did not include procedures to report all alleged violations and all substantiated incidents to the State Agency.	4 130	Continued from Page 14 3. Corrective Action/Systemic Changes: ' Compliance with timely and accurate event reporting will be monitored daily with stand up meeting discussion of prior 24 hours for facility review of orders for that day. The results of all investigations shall be reported to the Administrator of the facility or the designated representative and to other officials, including the department in accordance with the State Law within 5 working days of the incident. 4. Monitoring of Corrective Actions to Ensure No Recurrence: Results of this monitoring will be included in QA Report. Goal will be 90% for the 2nd quarter and 100% for the 3rd quarter by decrease in incidents.	10/17/16
4 134	11-94.1-29(e) Resident abuse, neglect, and misappropriation (e) The results of all investigations shall be reported to the administrator of the facility or the designated representative and to other officials, including the department, in accordance with state law within five working days of the incident. This Statute is not met as evidenced by: Based on record review and interview with staff members, the facility failed to ensure all alleged	4 134	4 134 11-94.1-29(e) Resident abuse, neglect, and Misappropriation 1. Corrective Action for Resident in Sample: Education inservice on 4 130 with staff will occur with signatures acknowledging understanding of Event Reporting of Incidents. 2. Identification of Other Residents Having the Potential of Being Affected: Unit nurses, nurse aides have been educated on event reporting for altercations as well as elopement; signatures acknowledge understanding. Other residents at risk for elopement/abuse will be identified through falls, safety, pain and nutrition at risk committee meetings as well as Grand rounds/Focus rounds done by NHA/designee, DON/designee, SDC, RSM.	10/17/16

Hawaii Dept. of Health, Office of Health C Assuranc

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4 134	Continued From page 15 violations related to neglect are reported to the State Survey Agency, and in accordance with state law within five working days of the incident. Findings include: On the afternoon of 9/15/16 a request was made to the Director of Nursing (DON) for incident reports related to the elopement and resident to resident altercation. The DON was agreeable to follow up on this request. On 9/16/16 at 9:00 A.M. the Nursing Home Administrator (NHA) and DON entered the conference room, inquired whether the facility completed an incident report and submitted the report to the State Agency. The NHA reported incident reports were not completed for the two incidents.	4 134	Continued from Page 15 3. Corrective Action/Systemic Changes: Compliance with timely and accurate event reporting will be monitored daily with stand up meeting discussion of prior 24 hours for facility review of orders for that day. 4. Monitoring of Corrective Actions to Ensure No Recurrence: Results of this monitoring will be included in QA Report. Goal will be 90% for the 2nd quarter and 100% for the 3rd quarter by decrease in incidents.	10/17/16

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4 134	Continued From page 16	4 134	4 134 11-94.1-29(e) Resident abuse, neglect, and Misappropriation See Pages 14-16	10/17/16
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 staff interviews and EMR reviews the facility failed to develop and implement policies and procedures that address all aspects of resident care needs to assist the resident to attain	4 136	4 136 11-94. 1-30 Resident Care See Page 18	10/17/16

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4 136	Continued From page 17	4 136	4 136 11-94. 1-30 Resident Care	10/17/16

Continued From page 17

and maintain the highest practicable health and medical status, including but not limited to the administration and tracking of influenza and pneumococcal immunizations for the residents.

Findings include:

On 09/16/2016 at 10:45 A.M,, interviewed the DON on the infection control and immunization practices of the facility. The DON stated that she has been in the position at the facility since June 2016 so on a "learning curve, " and working with Staff #17 to build upon existing infection control program. Queried how the facility tracked whether residents received the influenza and/or pneumococcal vaccine, and the DON stated that immunizations were tracked and logged on the EMR system and it could be printed out.

On 09/16/2016 at 11:30 A.M. accessed the EMR system to review the facility's influenza and pneumococcal tracking logs and Staff #4 provided assistance. Asked Staff #4 to print-out the influenza and pneumococcal immunization logs for all residents from date range of 06/01/2016 to 09/30/2016, and both sheets were printed with "No data found."

On 09/16/2016 at 11:46 A.M. interviewed Staff #17, who took the position of infection control coordinator on 08/22/2016. According to Staff #17 there were no immunization tracking logs from the previous administration, and she needed to go through each record to start tracking. The Staff #17 had began the task and provided a list of 23 residents that were provided the influenza vaccine from 09/09-14/2016. The Staff #17 stated that she did not start the pneumococcal and TB tracking and would have to create her own tracking log. Staff #17 was also planning to

4 136 11-94. 1-30 Resident Care — 10/17/16

1. Corrective action for Residents in Sample:
The DON, NHA and SDC met with licensed staff and discussed the facility policy infraction, in regards to proper tracking of pneumococcal and influenza immunizations. A review of guidelines for developing and implementing a spreadsheet was also conducted with this licensed staff with the emphasis on doing so at admission and during the proper immunization season; entering data into Point Click Care; documenting education, refusals and medical contraindications.
2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor the licensed staff involved, daily, weekly and at random to ensure compliance of proper tracking and documentation. This immunization tracking form will also include participation and collaboration from HR for monitoring employees on an annual basis; the anniversary date of hire.
3. Corrective action/Systemic Changes:
All licensed staff meeting was conducted, to review the facility policy and procedure on immunizations with the emphasis on ensuring all residents and staff were either educated on the risks/benefits, immunized or refused/medically contraindicated.
All licensed staff will be monitored during orientation, all residents upon admission, to ensure compliance of proper guidelines for immunizations, and to ensure no recurrence of this infraction.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee and NHA will conduct observations to every employee and resident weekly, monthly, and at random to ensure that licensed staff is in compliance with facility immunization guidelines. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate.

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4 136	Continued From page 18 do an immunization tracking form for the employees, as the current administration did not have any infection control tracking methods developed.	4 136	4 136 11-94. 1-30 Resident Care See Page 18	10/17/16
4 145	11-94.1-38(a) Activities (a) The facility must provide for an ongoing program of age-appropriate activities designed to meet the interests, physical, mental, and psychosocial well-being of each resident. This Statute is not met as evidenced by: Based on record review and interview the facility failed to provide an ongoing program of age-appropriate activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being for one of the 38 residents in the resident sample. Finding includes:	4 145	4 145 11-94. 1-38(a) Activities 1. Corrective Action for Resident in Sample: Staff was inserviced on the credentialing of a qualified person in accordance with each residents written plan of care. 2. Identification of Other Residents Having the Potential of Being Affected: DON/designee, NHA will monitor staff involved daily, weekly & at random to ensure compliance of proper tracking & documentation. 3. Corrective Action/Systemic Changes: Staff to conduct one on one visits every day in the morning. Continue activity evaluation upon admission and every 3 months then annually. Resident council every month. Ohana Council every month. 4. Monitoring of Corrective Actions to Ensure No Recurrence: Individual Activity Log to audit participation in activities. Monitor results will be reported to the QA meeting & necessary actions will be implemented as appropriate. Goal will be 90% for 2nd quarter & 100% for 3rd quarter.	10/17/16

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4 145	Continued From page 19	4 145	4 145 11-94. 1-38(a) Activities 1. Corrective Action for Resident in Sample: Staff was inserviced on the credentialing of a qualified person in accordance with each residents written plan of care. 2. Identification of Other Residents Having the Potential of Being Affected: DON/designee, NHA will monitor staff involved daily, weekly & at random to ensure compliance of proper tracking & documentation. 3. Corrective Action/Systemic Changes: Staff to conduct one on one visits every day in the morning. Continue activity evaluation upon admission and every 3 months then annually. Resident council every month. Ohana Council every month. 4. Monitoring of Corrective Actions to Ensure No Recurrence: Individual Activity Log to audit participation in activities. Monitor results will be reported to the QA meeting & necessary actions will be implemented as appropriate. Goal will be 90% for 2nd quarter & 100% for 3rd quarter.	10/17/16
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:	4 148	4 148 11-94.1-39(a) Nursing Services 1. Corrective Action for Resident in Sample: The DON, NHA and SDC met with licensed staff involved and discussed the facility policy infraction, in regards to insufficient staff, providing proper training and knowledge in the care plans of each Resident to achieve the highest practicable physical, mental and psychosocial well being; the development of careplanning policy as a basis for comprehensive assessments to ensure each residents needs are identified and met through care planning goals and outcome measurements. A review of the proper staffing per National standards was also conducted with the emphasis on ensuring sufficient nursing staff to reach the residents' highest practicable level of function.	10/17/16

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4 148	Continued From page 20 Based on observations, record reviews, interviews, and facility policy review, the facility failed to provide nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. This was evidenced by the staff's inability to provide needed care to residents to enable the residents to reach their highest practicable physical, mental and psychosocial well-being and includes the cumulative findings in the cited areas stated below. Findings include: 1. Interviews with residents, family members and staff validated the lack of the delivery of necessary provision of care and services to the residents at this facility. There is also the failure by administration to ensure their staff are trained and knowledgeable in the care plans of each resident to be able to deliver the individualized care required to achieve the highest practicable physical, mental and psychosocial well-being for each resident, current and/or discharged. Again, this was not found as evidenced by the deficient practices found in each citation at 4088, 4115, 4130, 4134, 4136, 4145, 4149, 4152, 4153, 4154, 4174, 4175, 4184 and 4203. Moreover, the facility did not have its own developed policy for care planning, which is the basis by which comprehensive assessments are formulated to ensure each resident's care needs are identified and met through outlined care planning goals and outcome measurements.	4 148	Continued from Page 20 2. Identification of other Resident Having the Potential of Being Affected: The DON/designee will monitor the staff involved daily, weekly and at random to ensure orientation includes competency skills check lists prior to placement on the units; shadowing of staff for orientation includes training in care planning, resident preferences and individual needs. 3. Corrective and Systemic Changes: All licensed staff meeting was conducted to review the facility policy and procedure for hiring and training of new personnel, with the emphasis on ensuring knowledge of the uniqueness of each individual resident and their individualized plan of care and to ensure no recurrence of infraction. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee will conduct audits and observation of licensed staff daily, weekly, monthly and at random to ensure that every licensed staff is competent and capable of providing individualized quality care to Residents to enable the Resident to achieve and maintain their highest level of wellbeing. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. Data analysis and trends will be monitored by QAPI, 3rd Friday at 8am, once per month.	10/17/16
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following:	4 149	4 149 11-94.1-39(b) Nursing Services See Page 22	10/17/16

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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	(X5) COMPLETE DATE
4 149	Continued From page 21 (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, record review, staff interviews and a review of the facility's policy, the facility did not ensure the resident's environment remained free of accident hazards and that each resident receives adequate supervision and assistive devices to prevent accidents for 7 of 38 residents reviewed for accidents, and failed to demonstrate ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. As a result, one resident sustained skin wounds to his forearms without a documented fall, other residents have had multiple falls but without updated care plans or falls risk assessments implemented, one resident had the potential for choking and one	4 149	4 149 11-94.1-39(b) Nursing Services 1. Corrective Action for Resident in Sample: The DON, NHA and SDC met with the licensed staff involved and discussed the facility policy infraction, in regards to ensuring that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A review of proper fall protocol and guidelines was also conducted with licensed staff with the emphasis on care plans and fall risk assessments; indications of whether the resident is a Level I or Level II fall risk, interventions specific to the careplan as preventive fall recurrence measures. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the licensed staff involved, daily, weekly and at random to ensure compliance with proper fall policy and safety protocols. 3. Corrective Actions/Systemic changes: All staff meeting was conducted to review the facility policy of falls and safety protocols with the emphasis on preventive measures, careplan interventions and root cause analysis. Restorative Nursing, Rehab services and Nurse, and aides will 'huddle' and discuss with resident the circumstances surrounding the event. User defined assessments such as Falls, Skin, Pain will be completed as well as careplan updated and intervention noted. All instances will be monitored to ensure compliance with facility policy and to ensure no recurrence of the infraction. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/NHA/designee will conduct administrative observations of Falls events daily, weekly, monthly and at random to ensure that every licensed staff is in compliance with facility's policy for Falls and Fall Prevention. Tracking of pertinent documentation and associated changes with careplans will be audited and incorporated with QAPI for monitoring effectiveness of the preventive measures will be graphed with patterns, trends and data. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. QA goal will be 90% compliance in the 2nd quarter & 100% compliance in the 3rd quarter.	10/17/16

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125065	A. BUILDING: ______ B. WING ______	09/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HILO REHABILITATION & NURSING C	563 KAUMANA DRIVE HILO, HI 96720

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4 149	Continued From page 22 resident with eloping/wandering behavior and hitting other residents. Findings include:	4 149	4 149 11-94.1-39(b) Nursing services 1. Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function. 3. Corrective and Systemic Changes: All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%	10/17/16

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4 149	Continued From page 23 Prevention policy as it did not indicate whether the resident was a Level I or Level II fall risk.	4 149	4 149 11-94.1-39(b) Nursing services 1. Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function. 3. Corrective and Systemic Changes: All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%	10/17/16

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4 149	Continued From page 24	4 149	4 149 11-94.1-39(b) Nursing services	10/17/16

4 149 11-94.1-39(b) Nursing services

1. Corrective Action for Resident in Sample:
   The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
2. Identification of Other Resident Having the Potential of Being Affected:
   The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.
3. Corrective and Systemic Changes:
   All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
   The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 149	Continued From page 25	4 149	4 149 11-94.1-39(b) Nursing services 1. Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function. 3. Corrective and Systemic Changes: All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%	10/17/16

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4 149	Continued From page 26	4 149	4 149 11-94.1-39(b) Nursing services 1. Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function. 3. Corrective and Systemic Changes: All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%	10/17/16

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4 149	Continued From page 27	4 149	4 149 11-94.1-39(b) Nursing services	10/17/16

4 149 11-94.1-39(b) Nursing services

1. Corrective Action for Resident in Sample:
The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.
3. Corrective and Systemic Changes:
All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 149	Continued From page 28	4 149	4 149 11-94.1-39(b) Nursing services	10/17/16

4 149 11-94.1-39(b) Nursing services

1. Corrective Action for Resident in Sample:
   The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
2. Identification of Other Resident Having the Potential of Being Affected:
   The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.
3. Corrective and Systemic Changes:
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4. Monitoring of Corrective Actions to Ensure No Recurrence:
   The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 149	Continued From page 29	4 149	4 149 11-94.1-39(b) Nursing services	10/17/16

4 149 11-94.1-39(b) Nursing services

1. Corrective Action for Resident in Sample:
The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.
3. Corrective and Systemic Changes:
All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 149	Continued From page 30	4 149	4 149 11-94.1-39(b) Nursing services	10/17/16

4 149 11-94.1-39(b) Nursing services

1. Corrective Action for Resident in Sample:
   The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
2. Identification of Other Resident Having the Potential of Being Affected:
   The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.
3. Corrective and Systemic Changes:
   All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
   The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 149	Continued From page 31	4 149	4 149 11-94.1-39(b) Nursing services	10/17/16

4 149 11-94.1-39(b) Nursing services

1. Corrective Action for Resident in Sample:
The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.
3. Corrective and Systemic Changes:
All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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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 ...PRIATE	(X5) COMPLETE DATE
4 149	Continued From page 32	4 149	4 149 11-94.1-39(b) Nursing services	10/17/16

4 149 11-94.1-39(b) Nursing services

1. Corrective Action for Resident in Sample:
The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.
3. Corrective and Systemic Changes:
All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

Hawaii Dept. of Health, Office of Healt. Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125065	A. BUILDING: ____ B. WING ____	09/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HILO REHABILITATION & NURSING C	563 KAUMANA DRIVE HILO, HI 96720

(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 ...TE	(X5) COMPLETE DATE
4 149	Continued From page 33	4 149	see below	10/17/16

4 149 11-94.1-39(b) Nursing services

1. Corrective Action for Resident in Sample:
   The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
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4. Monitoring of Corrective Actions to Ensure No Recurrence:
   The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125065	A. BUILDING: ______ B. WING ______	09/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HILO REHABILITATION & NURSING C	563 KAUMANA DRIVE HILO, HI 96720

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4 149	Continued From page 34	4 149	4 149 11-94.1-39(b) Nursing services 1. Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function. 3. Corrective and Systemic Changes: All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%	10/17/16

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
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4 149	Continued From page 35	4 149	4 149 11-94.1-39(b) Nursing services	10/17/16

4 149 11-94.1-39(b) Nursing services

1. Corrective Action for Resident in Sample:
   The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125065	A. BUILDING: ____ B. WING ____	09/19/2016

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LEGACY HILO REHABILITATION & NURSING C	563 KAUMANA DRIVE HILO, HI 96720

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4 149	Continued From page 36	4 149	4 149 11-94.1-39(b) Nursing services	10/17/16

4 149 11-94.1-39(b) Nursing services

1. Corrective Action for Resident in Sample:
The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
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	125065	A. BUILDING: ____ B. WING ____	09/19/2016

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4 149	Continued From page 37	4 149	4 149 11-94.1-39(b) Nursing services	10/17/16

4 149 11-94.1-39(b) Nursing services

1. Corrective Action for Resident in Sample:
   The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
2. Identification of Other Resident Having the Potential of Being Affected:
   The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.
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4. Monitoring of Corrective Actions to Ensure No Recurrence:
   The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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
	125065	A. BUILDING: ______ B. WING ______	09/19/2016

NAME OF PROVIDER OR SUPPLIER: LEGACY HILO REHABILITATION & NURSING C

STREET ADDRESS, CITY, STATE, ZIP CODE: 563 KAUMANA DRIVE, HILO, HI 96720

(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 ... RIATE	(X5) COMPLETE DATE
4 149	Continued From page 38	4 149	see below	10/17/16

4 149 11-94.1-39(b) Nursing Services

Corrective Action for Resident in Sample:

The DON, NHA and SDC met with the licensed staff involved and discussed the facility policy infraction, in regards to ensuring that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A review of proper fall protocol and guidelines was also conducted with licensed staff with the emphasis on care plans and fall risk assessments; indications of whether the resident is a Level I or Level II fall risk, interventions specific to the careplan as preventive fall recurrence measures.

1. Identification of Other Resident Having the Potential of Being Affected:
   The DON/designee will monitor the licensed staff involved, daily, weekly and at random to ensure compliance with proper fall policy and safety protocols.
2. Corrective Actions/Systemic changes:
   All staff meeting was conducted to review the facility policy of falls and safety protocols with the emphasis on preventive measures, careplan interventions and root cause analysis. Restorative Nursing, Rehab services and Nurse, and aides will 'huddle' and discuss with resident the circumstances surrounding the event. User defined assessments such as Falls, Skin, Pain will be completed as well as careplan updated and intervention noted. All instances will be monitored to ensure compliance with facility policy and to ensure no recurrence of the infraction.
3. Monitoring of Corrective Actions to Ensure No Recurrence:
   The DON/NHA/designee will conduct administrative observations of Falls events daily, weekly, monthly and at random to ensure that every licensed staff is in compliance with facility's policy for Falls and Fall Prevention. Tracking of pertinent documentation and associated changes with careplans will be audited and incorporated with QAPI for monitoring effectiveness of the preventive measures will be graphed with patterns, trends and data. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. QA goal will be 90% compliance in the 2nd quarter & 100% compliance in the 3rd quarter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 149	Continued From page 39	4 149	see below	10/17/16

4 149 11-94.1-39(b) Nursing Services

1. Corrective Action for Resident in Sample:
The DON, NHA and SDC met with the licensed staff involved and discussed the facility policy infraction, in regards to ensuring that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A review of proper fall protocol and guidelines was also conducted with licensed staff with the emphasis on care plans and fall risk assessments; indications of whether the resident is a Level I or Level II fall risk, interventions specific to the careplan as preventive fall recurrence measures.
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The DON/designee will monitor the licensed staff involved, daily, weekly and at random to ensure compliance with proper fall policy and safety protocols.
3. Corrective Actions/Systemic changes:
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4 149	Continued From page 40	4 149	4 149 11-94.1-39(b) Nursing services	10/17/16

1. Corrective Action for Resident in Sample:
   The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
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4. Monitoring of Corrective Actions to Ensure No Recurrence:
   The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 152	Continued From page 41	4 152		
4 152	11-94.1-39(e) Nursing services	4 152	4 152 11-94. 1-39(e) Nursing services	10/17/16

(e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures. The policies and procedures shall include but not be limited to:

(1) Written procedures for personnel to follow in an emergency including:

(A) Care of the resident;

(B) Notification of the attending physician and other persons responsible for the resident; and

(C) Arrangements for transportation, hospitalization, or other appropriate services;

(2) All treatment and care provided relative to the resident's needs and requirements for documentation; and

(3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized

This Statute is not met as evidenced by:
Based on observations, resident and staff interviews, the facility failed to maintain professional standards of practice, including medication or drug administration procedures that clearly define drug administration process and documentation for 1 of 38 residents

Provider's Plan of Correction:

4 152 11-94. 1-39(e) Nursing services

1. Corrective Action for Resident in Sample:
The DON and SDCs discusssed with the licensed staff involved and discussed the facility policy infraction, in regards to failing to maintain professional standards of conduct when making changes to medication schedules, notifying the physician in a timely manner for the clarification on medication administration time. A review of proper medication administration guidelines was also conducted with the involved staff, with the emphasis on the residents' preference, documentation and notification to the physician of the medication administration time change, and involvement of the pharmaceutical representative as needed.
2. Identification of Other Resident Having the Potential of Being Affected:
The DON /designee will monitor the licensed staff involved weekly, and at random to ensure compliance of proper medication administration procedure, and that residents are receiving medications at preferred times and that the physician is aware of and in agreement with medication administrative times.
3. Corrective Action/Systemic Changes:
All licensed staff meeting was conducted, to review the facility medication administration policy and procedure with the emphasis on ensuring the resident is comfortable with the administrative time, the medication will be of therapeutic value at the preferred time and that the physician is aware of the administrative time. All licensed staff will be monitored during medication administration procedures to ensure compliance with guidelines, residents' satisfaction and to ensure no recurrence of the above infractions.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee and the Pharmacy consultant will conduct medication administration observations with licensed staff weekly, monthly and at random to ensure that licensed staff is in compliance with the facility's medication administration guidelines and have referenced the residents' preferred time, have determined that the medication will be of therapeutic value and that the physician is in agreement with the administration time frame. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriately. Our goal for the 2nd quarter is 90 % and for the 3rd quarter, 100%.

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4 152	Continued From page 42 reviewed. Findings include:	4 152	4 152 11-94. 1-39(e) Nursing services (see below)	10/17/16

4 152 11-94. 1-39(e) Nursing services

1. Corrective Action for Resident in Sample:
   The DON and SDCs discusssed with the licensed staff involved and discussed the facility policy infraction, in regards to failing to maintain professional standards of conduct when making changes to medication schedules, notifying the physician in a timely manner for the clarification on medication administration time. A review of proper medication administration guidelines was also conducted with the involved staff, with the emphasis on the residents' preference, documentation and notification to the physician of the medication administration time change, and involvement of the pharmaceutical representative as needed.
2. Identification of Other Resident Having the Potential of Being Affected:
   The DON /designee will monitor the licensed staff involved weekly, and at random to ensure compliance of proper medication administration procedure, and that residents are receiving medications at preferred times and that the physician is aware of and in agreement with medication administrative times.
3. Corrective Action/Systemic Changes:
   All licensed staff meeting was conducted, to review the facility medication administration policy and procedure with the emphasis on ensuring the resident is comfortable with the administrative time, the medication will be of therapeutic value at the preferred time and that the physician is aware of the administrative time. All licensed staff will be monitored during medication administration procedures to ensure compliance with guidelines, residents' satisfaction and to ensure no recurrence of the above infractions.
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HILO REHABILITATION & NURSING C	**563 KAUMANA DRIVE HILO, HI 96720**

(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	(X5) COMPLETE DATE
4 152	Continued From page 43	4 152	4 152 11-94. 1-39(e) Nursing services	10/17/16

4 152 11-94. 1-39(e) Nursing services

1. Corrective Action for Resident in Sample:
   The DON and SDCs discusssed with the licensed staff involved and discussed the facility policy infraction, in regards to failing to maintain professional standards of conduct when making changes to medication schedules, notifying the physician in a timely manner for the clarification on medication administration time. A review of proper medication administration guidelines was also conducted with the involved staff, with the emphasis on the residents' preference, documentation and notification to the physician of the medication administration time change, and involvement of the pharmaceutical representative as needed.
2. Identification of Other Resident Having the Potential of Being Affected:
   The DON /designee will monitor the licensed staff involved weekly, and at random to ensure compliance of proper medication administration procedure, and that residents are receiving medications at preferred times and that the physician is aware of and in agreement with medication administrative times.
3. Corrective Action/Systemic Changes:
   All licensed staff meeting was conducted, to review the facility medication administration policy and procedure with the emphasis on ensuring the resident is comfortable with the administrative time, the medication will be of therapeutic value at the preferred time and that the physician is aware of the administrative time. All licensed staff will be monitored during medication administration procedures to ensure compliance with guidelines, residents' satisfaction and to ensure no recurrence of the above infractions.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
   The DON/designee and the Pharmacy consultant will conduct medication administration observations with licensed staff weekly, monthly and at random to ensure that licensed staff is in compliance with the facility's medication administration guidelines and have referenced the residents' preferred time, have determined that the medication will be of therapeutic value and that the physician is in agreement with the administration time frame. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriately. Our goal for the 2nd quarter is 90 % and for the 3rd quarter, 100%.

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4 152	Continued From page 44	4 152	4 152 11-94. 1-39(e) Nursing services See Pages 42-45	10/17/16
4 153	11-94.1-40(a) Dietary services (a) The food and nutritional needs of the residents shall be met through a nourishing, well-balanced diet in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, and shall be adjusted for age, sex, activity, and disability. (1) At least three meals shall be served daily at regular times with not more than a fourteen hour span between a substantial evening meal and breakfast on the following day; (2) Between meals nourishment that is consistent with the resident's needs shall be offered routinely and shall include a regular schedule of hydration to meet each resident's needs; (3) Appropriate substitution of foods shall be	4 153	4 153 11-94. 1-40(a) Dietary Services 1. Corrective Action for Resident in Sample: The DON and NHA met with licensed staff involved and discussed the facility infraction, in regards to food palatability and providing evidence of food holding temperatures on the steam table. A review of proper food holding temperatures and palatability of food and fluids was also conducted with this staff with the emphasis on keeping the holding temperature of food items within guidelines and providing food and fluids that are nutritive in value, flavor and appearance; food that is palatable, attractive and at the proper temperature. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor staff involved, daily, weekly, monthly and at random, to ensure compliance with proper food holding temperature and with providing food/fluid that is palatable, attractive and at the proper temperature. Interviews with residents on a random basis, a minimum of 5 per week, to ascertain palatability is ongoing and serves as a basis for gaining consensus regarding menu changes.	10/17/16

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4 153	Continued From page 45 promptly offered to all residents as necessary; (4) Food shall be served in a form consistent with the needs of the resident and the resident's ability to consume it; (5) Food shall be served with appropriate utensils; (6) Residents needing special equipment, implements, or utensils to assist them when eating shall have the items provided by the facility; and (7) There shall be a sufficient number of competent personnel to fulfill the food and nutrition needs of residents. Paid feeding attendants shall be trained as per the facility's state-approved training protocol. This Statute is not met as evidenced by: Based on observations, staff interviews and EMR reviews the facility failed to offer food substitutes of similar nutritive value for 1 of 38 residents reviewed, and who refused pureed food. Findings include:	4 153	Continued from Page 45 3. Corrective Action/Systemic Changes: All licensed staff meeting was conducted to review the facility policy and procedure for food temperature and food/fluid palatability with the emphasis on the resident's preference and taste. The DSM will maintain a log indicating the temperature of the food as it is holding on the steam table. Other audit tools include Dining Room observations and Dining Room Coordinator which will engage residents in the assessing of temperature and palatability and to ensure no recurrence of the infraction. 4. Monitoring of Corrective Action to Ensure No Recurrence: The DON or designee will conduct audits of the audit logs/binders/tools in Kitchen and Dining room as well as observation, daily, weekly, monthly and at random to ensure that food temperature, palatability and flavor is in compliance with facility guidelines and measured by residents as satisfactory; the results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. QA goal will be 90% compliance in the 2nd quarter & 100% compliance in the 3rd quarter.	10/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 153	Continued From page 46	4 153	4 153 11-94. 1-40(a) Dietary Services	10/17/16

4 153 11-94. 1-40(a) Dietary Services

1. Corrective Action for Resident in Sample:
The DON and NHA met with licensed staff involved and discussed the facility infraction, in regards to food palatability and providing evidence of food holding temperatures on the steam table.
A review of proper food holding temperatures and palatability of food and fluids was also conducted with this staff with the emphasis on keeping the holding temperature of food items within guidelines and providing food and fluids that are nutritive in value, flavor and appearance; food that is palatable, attractive and at the proper temperature.
2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor staff involved, daily, weekly, monthly and at random, to ensure compliance with proper food holding temperature and with providing food/fluid that is palatable, attractive and at the proper temperature. Interviews with residents on a random basis, a minimum of 5 per week, to ascertain palatability is ongoing and serves as a basis for gaining consensus regarding menu changes.
3. Corrective Action/Systemic Changes:
All licensed staff meeting was conducted to review the facility policy and procedure for food temperature and food/fluid palatability with the emphasis on the resident's preference and taste. The DSM will maintain a log indicating the temperature of the food as it is holding on the steam table. Other audit tools include Dining Room observations and Dining Room Coordinator which will engage residents in the assessing of temperature and palatability and to ensure no recurrence of the infraction.
4. Monitoring of Corrective Action to Ensure No Recurrence:
The DON or designee will conduct audits of the audit logs/binders/tools in Kitchen and Dining room as well as observation, daily, weekly, monthly and at random to ensure that food temperature, palatability and flavor is in compliance with facility guidelines and measured by residents as satisfactory; the results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. QA goal will be 90% compliance in the 2nd quarter & 100% compliance in the 3rd quarter.

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NAME OF PROVIDER OR SUPPLIER: LEGACY HILO REHABILITATION & NURSING C

STREET ADDRESS, CITY, STATE, ZIP CODE: 563 KAUMANA DRIVE, HĪLO, HI 96720

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4 153	Continued From page 47	4 153	4 153 11-94. 1-40(a) Dietary Services See Pages 45-47	10/17/16
4 154	11-94.1-40(b) Dietary services (b) All diets prepared for residents shall be: (1) Prescribed by the resident's physician, physician assistant, or APRN with a record of the diet as ordered kept on file; (2) Planned, prepared, and served by qualified personnel according to diet prescription. The current Hawaii Dietetic Association Manual or The Manual of Clinical Dietetics of the American Dietetic Association or both shall be readily available to all medical, nursing, and food service personnel; (3) All diets shall appropriately meet the nutrient, texture, and fluid needs of each resident; and	4 154	4 154 11-94. 1-40(b) Dietary Services 1. Corrective action for resident in sample: The DON, NHA and SDC met with the licensed staff and discussed the facility policy infraction, in regards to providing nutritional care and services for impaired nutrition, and unplanned weight change. Staff received inservice on impaired nutrition & weights. 2. Identification of other Residents' Having the Potential of Being Affected: A review of personal preferences, food and liquid was conducted with licensed and unlicensed nursing staff with an emphasis on documenting weights taken at the first of the month with variances noted; documenting food/fluid consumption accurately and the importance of monitoring lab values, skin integrity and RD recommendations.	10/17/16

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4 154	Continued From page 48 (4) Therapeutic or special diets shall be planned by a dietitian and served accordingly as prescribed by the resident's physician, physician assistant, or APRN. This Statute is not met as evidenced by: Based on observations, EMR and MR reviews and staff interviews the facility failed to ensure that 1 of 38 sampled residents , was provided nutritional care and services for impaired nutrition and unplanned weight change, and thus, did not meet the nutrient, texture, and fluid needs of this one resident. Findings include:	4 154	Continued from Page 48 3. Corrective action/systemic changes: All licensed staff meeting was conducted, to review the facility policy for Nutrition and weight changes, with emphasis on accuracy with weight taking, meal/fluid consumption and monitoring of lab values, skin integrity and RD recommendations. Compliance will be monitored by resident outcomes – weight gain – and satisfaction. DSM will represent RD in all careplan and IDT meetings; will report any updated information to RD. Communication with DSM to RD to PCP and to DON will be maintained by DSM in a Binder labelled "Nutrition at Risk". 4. Monitoring of Corrective Action to Ensure No Recurrence: The DON/designee will conduct an observation of meetings and binder weekly, monthly and at random to ensure compliance with facility protocol for impaired nutrition. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. 2nd quarter goal will be 90% and 3rd quarter goal will be 100%.	10/17/16

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4 154	Continued From page 49	4 154	4 154 11-94. 1-40(b) Dietary Services 1. Corrective action for resident in sample: The DON, NHA and SDC met with the licensed staff and discussed the facility policy infraction, in regards to providing nutritional care and services for impaired nutrition, and unplanned weight change. Staff received inservice on impaired nutrition & weights. 2. Identification of other Residents' Having the Potential of Being Affected: A review of personal preferences, food and liquid was conducted with licensed and unlicensed nursing staff with an emphasis on documenting weights taken at the first of the month with variances noted; documenting food/fluid consumption accurately and the importance of monitoring lab values, skin integrity and RD recommendations. 3. Corrective action/systemic changes: All licensed staff meeting was conducted, to review the facility policy for Nutrition and weight changes, with emphasis on accuracy with weight taking, meal/fluid consumption and monitoring of lab values, skin integrity and RD recommendations. Compliance will be monitored by resident outcomes – weight gain – and satisfaction. DSM will represent RD in all careplan and IDT meetings; will report any updated information to RD. Communication with DSM to RD to PCP and to DON will be maintained by DSM in a Binder labelled "Nutrition at Risk". 4. Monitoring of Corrective Action to Ensure No Recurrence: The DON/designee will conduct an observation of meetings and binder weekly, monthly and at random to ensure compliance with facility protocol for impaired nutrition. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. 2nd quarter goal will be 90% and 3rd quarter goal will be 100%.	10/17/16

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4 154	Continued From page 50	4 154	4 154 11-94. 1-40(b) Dietary Services 1. Corrective action for resident in sample: The DON, NHA and SDC met with the licensed staff and discussed the facility policy infraction, in regards to providing nutritional care and services for impaired nutrition, and unplanned weight change. Staff received inservice on impaired nutrition & weights. 2. Identification of other Residents' Having the Potential of Being Affected: A review of personal preferences, food and liquid was conducted with licensed and unlicensed nursing staff with an emphasis on documenting weights taken at the first of the month with variances noted; documenting food/fluid consumption accurately and the importance of monitoring lab values, skin integrity and RD recommendations. 3. Corrective action/systemic changes: All licensed staff meeting was conducted, to review the facility policy for Nutrition and weight changes, with emphasis on accuracy with weight taking, meal/fluid consumption and monitoring of lab values, skin integrity and RD recommendations. Compliance will be monitored by resident outcomes – weight gain – and satisfaction. DSM will represent RD in all careplan and IDT meetings; will report any updated information to RD. Communication with DSM to RD to PCP and to DON will be maintained by DSM in a Binder labelled "Nutrition at Risk". 4. Monitoring of Corrective Action to Ensure No Recurrence: The DON/designee will conduct an observation of meetings and binder weekly, monthly and at random to ensure compliance with facility protocol for impaired nutrition. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. 2nd quarter goal will be 90% and 3rd quarter goal will be 100%.	10/17/16

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4 154	Continued From page 51	4 154	4 154 11-94. 1-40(b) Dietary Services 1. Corrective action for resident in sample: The DON, NHA and SDC met with the licensed staff and discussed the facility policy infraction, in regards to providing nutritional care and services for impaired nutrition, and unplanned weight change. Staff received inservice on impaired nutrition & weights. 2. Identification of other Residents' Having the Potential of Being Affected: A review of personal preferences, food and liquid was conducted with licensed and unlicensed nursing staff with an emphasis on documenting weights taken at the first of the month with variances noted; documenting food/fluid consumption accurately and the importance of monitoring lab values, skin integrity and RD recommendations. 3. Corrective action/systemic changes: All licensed staff meeting was conducted, to review the facility policy for Nutrition and weight changes, with emphasis on accuracy with weight taking, meal/fluid consumption and monitoring of lab values, skin integrity and RD recommendations. Compliance will be monitored by resident outcomes – weight gain – and satisfaction. DSM will represent RD in all careplan and IDT meetings; will report any updated information to RD. Communication with DSM to RD to PCP and to DON will be maintained by DSM in a Binder labelled "Nutrition at Risk". 4. Monitoring of Corrective Action to Ensure No Recurrence: The DON/designee will conduct an observation of meetings and binder weekly, monthly and at random to ensure compliance with facility protocol for impaired nutrition. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. 2nd quarter goal will be 90% and 3rd quarter goal will be 100%.	10/17/16

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4 154	Continued From page 52	4 154	4 154 11-94. 1-40(b) Dietary Services 1. Corrective action for resident in sample: The DON, NHA and SDC met with the licensed staff and discussed the facility policy infraction, in regards to providing nutritional care and services for impaired nutrition, and unplanned weight change. Staff received inservice on impaired nutrition & weights. 2. Identification of other Residents' Having the Potential of Being Affected: A review of personal preferences, food and liquid was conducted with licensed and unlicensed nursing staff with an emphasis on documenting weights taken at the first of the month with variances noted; documenting food/fluid consumption accurately and the importance of monitoring lab values, skin integrity and RD recommendations. 3. Corrective action/systemic changes: All licensed staff meeting was conducted, to review the facility policy for Nutrition and weight changes, with emphasis on accuracy with weight taking, meal/fluid consumption and monitoring of lab values, skin integrity and RD recommendations. Compliance will be monitored by resident outcomes – weight gain – and satisfaction. DSM will represent RD in all careplan and IDT meetings; will report any updated information to RD. Communication with DSM to RD to PCP and to DON will be maintained by DSM in a Binder labelled "Nutrition at Risk". 4. Monitoring of Corrective Action to Ensure No Recurrence: The DON/designee will conduct an observation of meetings and binder weekly, monthly and at random to ensure compliance with facility protocol for impaired nutrition. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. 2nd quarter goal will be 90% and 3rd quarter goal will be 100%.	10/17/16

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4 154	Continued From page 53	4 154	4 154 11-94. 1-40(b) Dietary Services 1. Corrective action for resident in sample: The DON, NHA and SDC met with the licensed staff and discussed the facility policy infraction, in regards to providing nutritional care and services for impaired nutrition, and unplanned weight change. Staff received inservice on impaired nutrition & weights. 2. Identification of other Residents' Having the Potential of Being Affected: A review of personal preferences, food and liquid was conducted with licensed and unlicensed nursing staff with an emphasis on documenting weights taken at the first of the month with variances noted; documenting food/fluid consumption accurately and the importance of monitoring lab values, skin integrity and RD recommendations. 3. Corrective action/systemic changes: All licensed staff meeting was conducted, to review the facility policy for Nutrition and weight changes, with emphasis on accuracy with weight taking, meal/fluid consumption and monitoring of lab values, skin integrity and RD recommendations. Compliance will be monitored by resident outcomes – weight gain – and satisfaction. DSM will represent RD in all careplan and IDT meetings; will report any updated information to RD. Communication with DSM to RD to PCP and to DON will be maintained by DSM in a Binder labelled "Nutrition at Risk". 4. Monitoring of Corrective Action to Ensure No Recurrence: The DON/designee will conduct an observation of meetings and binder weekly, monthly and at random to ensure compliance with facility protocol for impaired nutrition. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. 2nd quarter goal will be 90% and 3rd quarter goal will be 100%.	10/17/16

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4 154	Continued From page 54	4 154	4 154 11-94. 1-40(b) Dietary Services	10/17/16

4 154 11-94. 1-40(b) Dietary Services

1. Corrective action for resident in sample:
   The DON, NHA and SDC met with the licensed staff and discussed the facility policy infraction, in regards to providing nutritional care and services for impaired nutrition, and unplanned weight change. Staff received inservice on impaired nutrition & weights.
2. Identification of other Residents' Having the Potential of Being Affected:
   A review of personal preferences, food and liquid was conducted with licensed and unlicensed nursing staff with an emphasis on documenting weights taken at the first of the month with variances noted; documenting food/fluid consumption accurately and the importance of monitoring lab values, skin integrity and RD recommendations.
3. Corrective action/systemic changes:
   All licensed staff meeting was conducted, to review the facility policy for Nutrition and weight changes, with emphasis on accuracy with weight taking, meal/fluid consumption and monitoring of lab values, skin integrity and RD recommendations. Compliance will be monitored by resident outcomes – weight gain – and satisfaction. DSM will represent RD in all careplan and IDT meetings; will report any updated information to RD. Communication with DSM to RD to PCP and to DON will be maintained by DSM in a Binder labelled "Nutrition at Risk".
4. Monitoring of Corrective Action to Ensure No Recurrence:
   The DON/designee will conduct an observation of meetings and binder weekly, monthly and at random to ensure compliance with facility protocol for impaired nutrition. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. 2nd quarter goal will be 90% and 3rd quarter goal will be 100%.

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LEGACY HILO REHABILITATION & NURSING C	563 KAUMANA DRIVE HILO, HI 96720

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4 154	Continued From page 55	4 154	<u>4 154</u> 11-94. 1-40(b) Dietary Services 1. <u>Corrective action for resident in sample:</u> The DON, NHA and SDC met with the licensed staff and discussed the facility policy infraction, in regards to providing nutritional care and services for impaired nutrition, and unplanned weight change. Staff received inservice on impaired nutrition & weights. 2. <u>Identification of other Residents' Having the Potential of Being Affected:</u> A review of personal preferences, food and liquid was conducted with licensed and unlicensed nursing staff with an emphasis on documenting weights taken at the first of the month with variances noted; documenting food/fluid consumption accurately and the importance of monitoring lab values, skin integrity and RD recommendations. 3. <u>Corrective action/systemic changes:</u> All licensed staff meeting was conducted, to review the facility policy for Nutrition and weight changes, with emphasis on accuracy with weight taking, meal/fluid consumption and monitoring of lab values, skin integrity and RD recommendations. Compliance will be monitored by resident outcomes – weight gain – and satisfaction. DSM will represent RD in all careplan and IDT meetings; will report any updated information to RD. Communication with DSM to RD to PCP and to DON will be maintained by DSM in a Binder labelled "Nutrition at Risk". 4. <u>Monitoring of Corrective Action to Ensure No Recurrence:</u> The DON/designee will conduct an observation of meetings and binder weekly, monthly and at random to ensure compliance with facility protocol for impaired nutrition. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. 2nd quarter goal will be 90% and 3rd quarter goal will be 100%.	10/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125065	A. BUILDING: ______ B. WING ______	09/19/2016

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4 154	Continued From page 56	4 154	4 154 11-94. 1-40(b) Dietary Services 1. Corrective action for resident in sample: The DON, NHA and SDC met with the licensed staff and discussed the facility policy infraction, in regards to providing nutritional care and services for impaired nutrition, and unplanned weight change. Staff received inservice on impaired nutrition & weights. 2. Identification of other Residents' Having the Potential of Being Affected: A review of personal preferences, food and liquid was conducted with licensed and unlicensed nursing staff with an emphasis on documenting weights taken at the first of the month with variances noted; documenting food/fluid consumption accurately and the importance of monitoring lab values, skin integrity and RD recommendations. 3. Corrective action/systemic changes: All licensed staff meeting was conducted, to review the facility policy for Nutrition and weight changes, with emphasis on accuracy with weight taking, meal/fluid consumption and monitoring of lab values, skin integrity and RD recommendations. Compliance will be monitored by resident outcomes – weight gain – and satisfaction. DSM will represent RD in all careplan and IDT meetings; will report any updated information to RD. Communication with DSM to RD to PCP and to DON will be maintained by DSM in a Binder labelled "Nutrition at Risk". 4. Monitoring of Corrective Action to Ensure No Recurrence: The DON/designee will conduct an observation of meetings and binder weekly, monthly and at random to ensure compliance with facility protocol for impaired nutrition. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. 2nd quarter goal will be 90% and 3rd quarter goal will be 100%.	10/17/16

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4 154	Continued From page 57	4 154	4 154 11-94. 1-40(b) Dietary Services 1. Corrective action for resident in sample: The DON, NHA and SDC met with the licensed staff and discussed the facility policy infraction, in regards to providing nutritional care and services for impaired nutrition, and unplanned weight change. Staff received inservice on impaired nutrition & weights. 2. Identification of other Residents' Having the Potential of Being Affected: A review of personal preferences, food and liquid was conducted with licensed and unlicensed nursing staff with an emphasis on documenting weights taken at the first of the month with variances noted; documenting food/fluid consumption accurately and the importance of monitoring lab values, skin integrity and RD recommendations. 3. Corrective action/systemic changes: All licensed staff meeting was conducted, to review the facility policy for Nutrition and weight changes, with emphasis on accuracy with weight taking, meal/fluid consumption and monitoring of lab values, skin integrity and RD recommendations. Compliance will be monitored by resident outcomes – weight gain – and satisfaction. DSM will represent RD in all careplan and IDT meetings; will report any updated information to RD. Communication with DSM to RD to PCP and to DON will be maintained by DSM in a Binder labelled "Nutrition at Risk". 4. Monitoring of Corrective Action to Ensure No Recurrence: The DON/designee will conduct an observation of meetings and binder weekly, monthly and at random to ensure compliance with facility protocol for impaired nutrition. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. 2nd quarter goal will be 90% and 3rd quarter goal will be 100%.	10/17/16

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4 154	Continued From page 58	4 154	4 154 11-94. 1-40(b) Dietary Services See Pages 48-58	10/17/16
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	4 159	4 159 11-941. 1-41(a) Storage and Handling of Food See Page 60	10/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 159	Continued From page 59 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 policy review, observations, and interviews the facility failed to store, prepare, distribute, and serve food under sanitary conditions. The facility also failed to ensure dishes and utensils are cleaned and stored under sanitary conditions. In addition, based on observations and staff interview, the facility failed to ensure that staff followed proper hand sanitization and food handling practices for the prevention of foodborne illnesses. Findings include: 1) On 9/13/2016 at 9:33 A.M. in kitchen tour with the Food Service Manager (FSM) found the following food items without a label to indicate a used by or expiration date: one single serving cup of ice cream; a closed bag of tater tots identified by FSM as recently opened; one gallon tub of rainbow sherbet half full. In the cooking area resting on a shelf above the gas stove was a clear plastic pitcher about 3/4th full of yellow liquid which the FSM identified as cooking oil. When asked about proper storage the FSM stated the pitcher of oil should be covered and labeled. In the dry pantry storage was a shelf holding gallon sized canned foods; boxes of cream of wheat; boxes pancake mixes; and boxes of cake mixes all incompletely labeled with just month and day no year. The FSM explained that these items were the date received.	4 159	4 159 11-941. 1-41(a) Storage and Handling of Food 1. Corrective Action for Resident in Sample: The DON and NHA met with the staff involved and discussed the facility policy infraction in regards to the facility failing to store, prepare, distribute, and serve food under sanitary conditions, failing to ensure dishes and utensils are cleaned and stored under sanitary conditions, and failing to ensure that staff followed proper hand sanitization and food handling practices for the prevention of foodborne illnesses. All dietary staff received inservice on prevention of foodborne illness. A review of the proper food temperatures, proper cleansing of dishes/utensils, their storage and proper hand sanitizing; food handling by involved staff was also conducted with the emphasis on sanitary conditions and the prevention of foodborne illness. Inservice on 3 compartment cleansing & sink use, sanitizing testing, covering of food items, food items to be labeled with "to use by dates". 2. Identification of Other Resident Having the Potential of Being Affected: The DON /designee will monitor the licensed staff involved, daily, weekly, and at random, to ensure compliance with proper food temperatures, proper cleansing, proper hand sanitizing and proper storage. 3. Corrective Action/Systemic Changes: All licensed staff meeting was conducted to review the facility policy and procedure on storage, sanitizing, proper food temperatures, and cleansing. Logs/binders will be developed and maintained to monitor and track compliance. All involved staff will be monitored to ensure compliance with audit tools, no missing entries and no recurrence of the infraction. 4. Monitoring of Corrective actions to Ensure No Recurrence: The DON/DSM/designee will conduct observation and audits of the involved staff and binders/logs/documents daily, weekly, monthly and at random to ensure compliance with the facility guidelines for storage, sanitizing, food temperatures and cleansing. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. QA goals is 90% compliance 2nd quarter & 100% compliance 3rd quarter.	10/17/16

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4 159	Continued From page 60	4 159	4 159 11-94.1-41(a) Storage and handling of food	10/17/16

Continued From page 60

2) The facility failed to demonstrate that the quantenary sanitizing solution was at 150 - 400 ppm recommended for the 3 compartment sink used to wash large cooking and food prep items. On the morning of 9/13/2016 observed FSM test the sanitizing agent for the sink used to soak large cooking items using a litmus paper test strip. The FSM ran the sanitizing agent into a small tub then dipped the litmus test strip in the disinfectant tub for 10 seconds and removed. The test strip indicated a reading of less than 100 parts per million (ppm) the FSM manager stated, "I think it's water". When asked what ppm the facility followed, the FSM stated "between 200 - 400 ppm. On 9/16/2016 at 8:49 A.M. observed the 3rd compartment that held the sanitizing solution overflowing out of the compartment onto the counter. The Dietary Aide (DA) #1 was asked to test the 3rd compartment. The litmus test on the overflowing sink indicated less than 100 ppm. The DA drained the 3rd compartment and refilled the compartment with sanitizing solution to the recommended water level. The litmus test was repeated and indicated for the second time less than 100 ppm. Observed a chart above the sink that suggested the sanitizing reading should be between 150 - 400 ppm. On 9/16/16 at 11:56 A.M. the FSM provided a policy for Pot-Pan Washing (3 Compartment Sink), however the policy was titled for the previous facility management.

3) On 9/13/2016 during a noon meal observation, observed Staff #20 in the dining room bend in a kneeling position; touch a clean tray from the bottom of the food warming cart; stand; pull up her uniform pants; then without hand sanitizing remove a tray from the food warming cart and take the tray to R # 41 who was seated in the

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4 159 11-94.1-41(a) Storage and handling of food — 10/17/16

1. Corrective Action for Resident in Sample:
   The DON and NHA met with the staff involved and discussed the facility policy infraction in regards to the facility failing to store, prepare, distribute, and serve food under sanitary conditions, failing to ensure dishes and utensils are cleaned and stored under sanitary conditions, and failing to ensure that staff followed proper hand sanitization and food handling practices for the prevention of foodborne illnesses. All dietary staff received inservice on prevention of foodborne illness. A review of the proper food temperatures, proper cleansing of dishes/utensils, their storage and proper hand sanitizing; food handling by involved staff was also conducted with the emphasis on sanitary conditions and the prevention of foodborne illness. Inservice on 3 compartment cleansing & sink use, sanitizing testing, covering of food items, food items to be labeled with "to use by dates".
2. Identification of Other Resident Having the Potential of Being Affected:
   The DON /designee will monitor the licensed staff involved, daily, weekly, and at random, to ensure compliance with proper food temperatures, proper cleansing, proper hand sanitizing and proper storage.
3. Corrective Action/Systemic Changes:
   All licensed staff meeting was conducted to review the facility policy and procedure on storage, sanitizing, proper food temperatures, and cleansing. Logs/binders will be developed and maintained to monitor and track compliance. All involved staff will be monitored to ensure compliance with audit tools, no missing entries and no recurrence of the infraction.
4. Monitoring of Corrective actions to Ensure No Recurrence:
   The DON/DSM/designee will conduct observation and audits of the involved staff and binders/logs/documents daily, weekly, monthly and at random to ensure compliance with the facility guidelines for storage, sanitizing, food temperatures and cleansing. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. QA goals is 90% compliance 2nd quarter & 100% compliance 3rd quarter.

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4 159	Continued From page 61 dining room. Staff #20 proceeded to remove the protective coverings off the food dishes for R #41. When asked about hand sanitizing after kneeling and touching her uniform clothing, Staff #20 stated "I forgot to sanitize". 4) On 9/13/2016 during a noon meal observation in the dining room observed a serving cart with a meal tray waiting to be served with an uncovered dish of sliced sugar beets. The serving cart was waist level high and situated next to a sink in the dining room. Random staff were observed washing their hands between tray passes next to the serving cart with the uncovered sugar beet dish. On 9/14/2016 at 2:07 P.M. in an interview with the Food Service Manager (FSM) on the observed unwrapped dish of sugar beets in the dining room. The FSM stated the food warming cart delivered to the dining room holds trays for both the dining room residents and residents who eat in their room, the trays are sorted in the dining room. Trays being served to the dining room residents have uncovered side dishes, trays going to the resident rooms should be covered. In the process of sorting trays the uncovered food sits on the serving carts. The FSM acknowledged that uncovered food is an infection control concern. 5) On 9/16/2016 at 8:49 A.M. observed serving carts with trays holding plates and cups of partially eaten foods and liquids. The Dietary Aide #1 shared that these trays were collected from the residents completed morning meal and needed to be scrapped and cleaned. The serving cart sat next to a metal shelf. Hanging on the side of the metal shelf were pots and pans. When asked the DA #1 confirmed that the pots and pans on the shelf were clean. Observed no barrier between the clean shelf and serving cart	4 159	4 159 11-94.1-41(a) Storage and handling of food 1. Corrective Action for Resident in Sample: The DON and NHA met with the staff involved and discussed the facility policy infraction in regards to the facility failing to store, prepare, distribute, and serve food under sanitary conditions, failing to ensure dishes and utensils are cleaned and stored under sanitary conditions, and failing to ensure that staff followed proper hand sanitization and food handling practices for the prevention of foodborne illnesses. All dietary staff received inservice on prevention of foodborne illness. A review of the proper food temperatures, proper cleansing of dishes/utensils, their storage and proper hand sanitizing; food handling by involved staff was also conducted with the emphasis on sanitary conditions and the prevention of foodborne illness. Inservice on 3 compartment cleansing & sink use, sanitizing testing, covering of food items, food items to be labeled with "to use by dates". 2. Identification of Other Resident Having the Potential of Being Affected: The DON /designee will monitor the licensed staff involved, daily, weekly, and at random, to ensure compliance with proper food temperatures, proper cleansing, proper hand sanitizing and proper storage. 3. Corrective Action/Systemic Changes: All licensed staff meeting was conducted to review the facility policy and procedure on storage, sanitizing, proper food temperatures, and cleansing. Logs/binders will be developed and maintained to monitor and track compliance. All involved staff will be monitored to ensure compliance with audit tools, no missing entries and no recurrence of the infraction. 4. Monitoring of Corrective actions to Ensure No Recurrence: The DON/DSM/designee will conduct observation and audits of the involved staff and binders/logs/documents daily, weekly, monthly and at random to ensure compliance with the facility guidelines for storage, sanitizing, food temperatures and cleansing. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. QA goals is 90% compliance 2nd quarter & 100% compliance 3rd quarter.	10/17/16 10/17/16

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4 159

Continued From page 62

holding dirty plates and cups. When asked if the cart can be bumped causing food and liquid to splash onto the clean pots and pans the DA #1 stated the area is very narrow, gets crowded, splashing could occur. Later that day the FSM acknowledge that keeping the used meal trays on serving carts next to the clean shelf is a potential for the contamination.

6) During the dining observation on 09/13/2016 at 12:13 P.M. on the skilled nursing unit, it was found the residents' meal trays had uncovered foods such as the bowl of beets, bowl of fruit cocktail mix and orange juice, which were being delivered by the certified nurse aides on the unit. As these side dishes were not covered, there exists the potential for contamination of the food and drink before reaching the intended residents, such that the staff or an individual passing by during the tray delivery in the hallways inadvertenly coughed or sneezed.

4 159

4 159 11-94.1-41(a) Storage and handling of food

10/17/16

1. Corrective Action for Resident in Sample:
   The DON and NHA met with the staff involved and discussed the facility policy infraction in regards to the facility failing to store, prepare, distribute, and serve food under sanitary conditions, failing to ensure dishes and utensils are cleaned and stored under sanitary conditions, and failing to ensure that staff followed proper hand sanitization and food handling practices for the prevention of foodborne illnesses. All dietary staff received inservice on prevention of foodborne illness. A review of the proper food temperatures, proper cleansing of dishes/utensils, their storage and proper hand sanitizing; food handling by involved staff was also conducted with the emphasis on sanitary conditions and the prevention of foodborne illness. Inservice on 3 compartment cleansing & sink use, sanitizing testing, covering of food items, food items to be labeled with "to use by dates". — 10/17/16
2. Identification of Other Resident Having the Potential of Being Affected:
   The DON /designee will monitor the licensed staff involved, daily, weekly, and at random, to ensure compliance with proper food temperatures, proper cleansing, proper hand sanitizing and proper storage. — 10/17/16
3. Corrective Action/Systemic Changes:
   All licensed staff meeting was conducted to review the facility policy and procedure on storage, sanitizing, proper food temperatures, and cleansing. Logs/binders will be developed and maintained to monitor and track compliance. All involved staff will be monitored to ensure compliance with audit tools, no missing entries and no recurrence of the infraction.
4. Monitoring of Corrective actions to Ensure No Recurrence:
   The DON/DSM/designee will conduct observation and audits of the involved staff and binders/logs/documents daily, weekly, monthly and at random to ensure compliance with the facility guidelines for storage, sanitizing, food temperatures and cleansing. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. QA goals is 90% compliance 2nd quarter & 100% compliance 3rd quarter. — 10/17/16

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4 159	Continued From page 63	4 159	4 159 11-94.1-41(a) Storage and handling of food	

1. Corrective Action for Resident in Sample: — 10/17/16
The DON and NHA met with the staff involved and discussed the facility policy infraction in regards to the facility failing to store, prepare, distribute, and serve food under sanitary conditions, failing to ensure dishes and utensils are cleaned and stored under sanitary conditions, and failing to ensure that staff followed proper hand sanitization and food handling practices for the prevention of foodborne illnesses. All dietary staff received inservice on prevention of foodborne illness. A review of the proper food temperatures, proper cleansing of dishes/utensils, their storage and proper hand sanitizing; food handling by involved staff was also conducted with the emphasis on sanitary conditions and the prevention of foodborne illness. Inservice on 3 compartment cleansing & sink use, sanitizing testing, covering of food items, food items to be labeled with "to use by dates". — 10/17/16
2. Identification of Other Resident Having the Potential of Being Affected: — 10/17/16
The DON /designee will monitor the licensed staff involved, daily, weekly, and at random, to ensure compliance with proper food temperatures, proper cleansing, proper hand sanitizing and proper storage.
3. Corrective Action/Systemic Changes: — 10/17/16
All licensed staff meeting was conducted to review the facility policy and procedure on storage, sanitizing, proper food temperatures, and cleansing. Logs/binders will be developed and maintained to monitor and track compliance. All involved staff will be monitored to ensure compliance with audit tools, no missing entries and no recurrence of the infraction.
4. Monitoring of Corrective actions to Ensure No Recurrence:
The DON/DSM/designee will conduct observation and audits of the involved staff and binders/logs/documents daily, weekly, monthly and at random to ensure compliance with the facility guidelines for storage, sanitizing, food temperatures and cleansing. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. QA goals is 90% compliance 2nd quarter & 100% compliance 3rd quarter.

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4 159	Continued From page 64	4 159	4 159 11-941. 1-41(a) Storage and Handling of Food See Pages 60-64	10/17/16
				10/17/16
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 observations, record reviews, interviews and facility policy review, the facility failed to develop an individualized,	4 174	4 174 11-94.1-43(b) Interdisciplinary care process 1. Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.	10/17/16

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4 174	Continued From page 65 interdisciplinary comprehensive care plan for each resident 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 4 of 38 residents whose comprehensive care plans were reviewed. Findings include: 1. The policy and procedure provided by the NHA on 9/16/16 titled, "Care Planning for Residents" as Policy No. 40, is the previous management company's policy with no origination date. Further, in the body of this policy, it states under "Policy: (Other company's name) and its affiliated facilities...". As such, this policy produced by the NHA to be Legacy Hilo Rehabilitation & Nursing Center's policy and procedure on care planning for residents is not their policy, and no other policy was provided.	4 174	Continued from Page 65 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function. 3. Corrective and Systemic Changes: All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%	10/17/16 10/17/16 10/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125065	A. BUILDING: ______ B. WING ______	09/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HILO REHABILITATION & NURSING C	563 KAUMANA DRIVE HILO, HI 96720

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4 174	Continued From page 66	4 174	4 174 11-94.1-43(b) Interdisciplinary care process	

1. Corrective Action for Resident in Sample:
The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning. — 10/17/16

2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function. — 10/17/16

3. Corrective and Systemic Changes:
All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. — 10/17/16

4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 174	Continued From page 67	4 174	4 174 11-94.1-43(b) Interdisciplinary care process	

4 174 11-94.1-43(b) Interdisciplinary care process

1. Corrective Action for Resident in Sample:
The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning. — 10/17/16

2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.

3. Corrective and Systemic Changes:
All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process.

4. Monitoring of Corrective Actions to Ensure No Recurrence: — 10/17/16
The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 174	Continued From page 68	4 174	4 174 11-94.1-43(b) Interdisciplinary care process	

1. Corrective Action for Resident in Sample:
The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning. — 10/17/16

2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.

3. Corrective and Systemic Changes:
All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. — 10/17/16

4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 174	Continued From page 69	4 174	4 174 11-94.1-43(b) Interdisciplinary care process	

1. Corrective Action for Resident in Sample:
The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning. — 10/17/16

2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function. — 10/17/16

3. Corrective and Systemic Changes:
All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process.

4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 174	Continued From page 70	4 174	4 174 11-94.1-43(b) Interdisciplinary care process	

1. Corrective Action for Resident in Sample:
The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning. — 10/17/16

2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.

3. Corrective and Systemic Changes:
All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. — 10/17/16

4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 174	Continued From page 71	4 174	4 174 11-94.1-43(b) Interdisciplinary care process See Pages 65-71	10/17/16
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 observations, record reviews, interviews and facility policy review, the facility failed to ensure that residents' comprehensive care plans are periodically reviewed and revised by a team of qualified persons for 7 of the 38 residents in the resident sample review. Findings include: 1. The policy and procedure provided by the NHA on 9/16/16 titled, "Care Planning for Residents" as Policy No. 40, is the previous management company's policy with no origination date. Further, in the body of this policy, it states under "Policy: (Other company's name) and its affiliated facilities...". As such, this policy produced by the NHA to be Legacy Hilo Rehabilitation & Nursing Center's policy and procedure on care planning for residents is not their policy, and no other	4 175	4 175 11-94.1-43(c) Interdisciplinary care process 1. Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.	10/17/16 10/17/16

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4 175	Continued From page 72 policy was provided.	4 175	Continued from Page 72 3. Corrective and Systemic Changes: All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%	10/17/16 10/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 175	Continued From page 73	4 175	See below	10/17/16

4 175 11-94.1-43(c) Interdisciplinary care process

1. Corrective Action for Resident in Sample:
   The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
2. Identification of Other Resident Having the Potential of Being Affected:
   The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.
3. Corrective and Systemic Changes:
   All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
   The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 175	Continued From page 74	4 175	4 175 11-94.1-43(c) Interdisciplinary care process	10/17/16

4 175 11-94.1-43(c) Interdisciplinary care process

1. Corrective Action for Resident in Sample:
The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.
3. Corrective and Systemic Changes:
All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 175	Continued From page 75	4 175	4 175 11-94.1-43(c) Interdisciplinary care process 1. Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function. 3. Corrective and Systemic Changes: All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%	10/17/16 10/17/16

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4 175	Continued From page 76	4 175	4 175 11-94.1-43(c) Interdisciplinary care process 1. Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.	10/17/16
			2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.	10/17/16
			3. Corrective and Systemic Changes: All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process.	
			4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125065	A. BUILDING: ____ B. WING ____	09/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HILO REHABILITATION & NURSING C	563 KAUMANA DRIVE HILO, HI 96720

(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	(X5) COMPLETE DATE
4 175	Continued From page 77	4 175	4 175 11-94.1-43(c) Interdisciplinary care process	10/17/16

4 175 11-94.1-43(c) Interdisciplinary care process

1. Corrective Action for Resident in Sample:
   The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
2. Identification of Other Resident Having the Potential of Being Affected:
   The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.
3. Corrective and Systemic Changes:
   All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
   The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 175	Continued From page 78	4 175	4 175 11-94.1-43(c) Interdisciplinary care process	10/17/16

1. Corrective Action for Resident in Sample:
   The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning.
2. Identification of Other Resident Having the Potential of Being Affected:
   The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.
3. Corrective and Systemic Changes:
   All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
   The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 175	Continued From page 79	4 175	4 175 11-94.1-43(c) Interdisciplinary care process	

1. Corrective Action for Resident in Sample:
The DON, NHA and SDC met with the staff involved and discussed the facility policy infraction, in regards to comprehensive assessments, development of comprehensive careplans, cross reference to unnecessary drugs and their right to participate in careplanning with an emphasis on accuracy in coding, collaboration with Rehab for Section GG, review of medication regimens, and the residents' right to participate with careplanning. — 10/17/16

2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor the involved staff weekly and at random to ensure compliance with proper coding of functional limitations in ROM, that Medications are appropriate for usage with PRNs' documented as well as behavioral logs completed; all residents will have careplan meetings scheduled upon which their Individualized plan of care will be updated to reflect measurable and realistic goals designed to achieve the highest practicable level of function.

3. Corrective and Systemic Changes:
All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, unnecessary medication and participation with Careplanning. The emphasis is on accurate assessments, individualized careplans, discontinuance of unnecessary medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. — 10/17/16

4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and at random, to ensure that we are in compliance with facility's administrative guidelines for assessment, careplanning and the medication administration protocol; completion of appropriate behavioral logs and documentation of the effectiveness of PRN and scheduled medications. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The 2nd quarter goal is 90% and the 3rd quarter goal is 100%

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4 175	Continued From page 80	4 175	4 175 11-94.1-43(c) Interdisciplinary care process See Pages 72-80	10/17/16
4 184	11-94.1-46(a) Pharmaceutical services (a) Each facility shall employ a licensed pharmacist, or shall have a written contractual arrangement with a licensed pharmacist, to provide consultation on methods and procedures for ordering, storing, administering, disposing, and recordkeeping of drugs and biologicals, and provisions for emergency service. This Statute is not met as evidenced by: Based on record review and interview with staff members, the facility failed to ensure 1 (Resident #36) of 5 residents selected for medication review and one add-on resident is free from unnecessary drugs. Findings include:	4 184	4 184 11-94.1-46(a) Pharmaceutical services 1. Corrective action for resident in sample: The DON, NHA and SDC met with the licensed staff involved and discussed the facility policy Infraction in regards to ensuring that resident are not using unnecessary drugs; and residents who do use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, in an effort to is continue these drugs. A review of each residents' drug regimen will be conducted by DON and pharmaceutical representative with recommendations to PCPs as indicated for discontinuance of unnecessary medications and/or gradual dose reductions. 2. Identification of Other Residents Having the Potential of Being Affected: The DON/designee will receive orders daily at stand up to increase awareness of the drugs being ordered and the potential for unnecessary medication. The DON/designee will monitor the Licensed staff involved daily, weekly, at random, to ensure communication with PCP thru use of a binder keeping copies of faxes/encounters/communication with PCP; duplicated in nursing notes nevertheless available to PCP upon visit to unit. Careplan revisions will then be made as appropriate.	10/17/16

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4 184	Continued From page 81	4 184	4 184 11-94.1-46(a) Pharmaceutical services	10/17/16

4 184 11-94.1-46(a) Pharmaceutical services

1. Corrective action for resident in sample:
   The DON, NHA and SDC met with the licensed staff involved and discussed the facility policy Infraction in regards to ensuring that resident are not using unnecessary drugs; and residents who do use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, in an effort to is continue these drugs. A review of each residents' drug regimen will be conducted by DON and pharmaceutical representative with recommendations to PCPs as indicated for discontinuance of unnecessary medications and/or gradual dose reductions.
2. Identification of Other Residents Having the Potential of Being Affected:
   The DON/designee will receive orders daily at stand up to increase awareness of the drugs being ordered and the potential for unnecessary medication. The DON/designee will monitor the Licensed staff involved daily, weekly, at random, to ensure communication with PCP thru use of a binder keeping copies of faxes/encounters/communication with PCP; duplicated in nursing notes nevertheless available to PCP upon visit to unit. Careplan revisions will then be made as appropriate.

   Continued from Page 81
3. Corrective Action/Systemic Change:
   All licensed staff meeting was conducted to review the facility policy in regards to ensuring residents are not receiving unnecessary medications, gradual dose reductions occur where indicated and behavioral interventions are appropriate and careplanned.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
   The DON/designee and Pharmacy Consultant will conduct reviews of the resident orders and medication regimen weekly, monthly and at random to ensure that all licensed staff is aware of facility policy regarding GDR and unnecessary medications. The results of the monitoring will be reported to the quarterly QA meetings and action will be implemented as appropriate. The goal will be 90% for the 2nd quarter and 100% for the 3rd quarter.

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4 184	Continued From page 82	4 184	4 184 11-94.1-46(a) Pharmaceutical services	10/17/16

1. Corrective action for resident in sample:
The DON, NHA and SDC met with the licensed staff involved and discussed the facility policy Infraction in regards to ensuring that resident are not using unnecessary drugs; and residents who do use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, in an effort to is continue these drugs. A review of each residents' drug regimen will be conducted by DON and pharmaceutical representative with recommendations to PCPs as indicated for discontinuance of unnecessary medications and/or gradual dose reductions.
2. Identification of Other Residents Having the Potential of Being Affected:
The DON/designee will receive orders daily at stand up to increase awareness of the drugs being ordered and the potential for unnecessary medication. The DON/designee will monitor the Licensed staff involved daily, weekly, at random, to ensure communication with PCP thru use of a binder keeping copies of faxes/encounters/communication with PCP; duplicated in nursing notes nevertheless available to PCP upon visit to unit. Careplan revisions will then be made as appropriate.
3. Corrective Action/Systemic Change:
All licensed staff meeting was conducted to review the facility policy in regards to ensuring residents are not receiving unnecessary medications, gradual dose reductions occur where indicated and behavioral interventions are appropriate and careplanned.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee and Pharmacy Consultant will conduct reviews of the resident orders and medication regimen weekly, monthly and at random to ensure that all licensed staff is aware of facility policy regarding GDR and unnecessary medications. The results of the monitoring will be reported to the quarterly QA meetings and action will be implemented as appropriate. The goal will be 90% for the 2nd quarter and 100% for the 3rd quarter.

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4 184	Continued From page 83	4 184	4 184 11-94.1-46(a) Pharmaceutical services 1. Corrective action for resident in sample: The DON, NHA and SDC met with the licensed staff involved and discussed the facility policy Infraction in regards to ensuring that resident are not using unnecessary drugs; and residents who do use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, in an effort to is continue these drugs. A review of each residents' drug regimen will be conducted by DON and pharmaceutical representative with recommendations to PCPs as indicated for discontinuance of unnecessary medications and/or gradual dose reductions. 2. Identification of Other Residents Having the Potential of Being Affected: The DON/designee will receive orders daily at stand up to increase awareness of the drugs being ordered and the potential for unnecessary medication. The DON/designee will monitor the Licensed staff involved daily, weekly, at random, to ensure communication with PCP thru use of a binder keeping copies of faxes/encounters/communication with PCP; duplicated in nursing notes nevertheless available to PCP upon visit to unit. Careplan revisions will then be made as appropriate. 3. Corrective Action/Systemic Change: All licensed staff meeting was conducted to review the facility policy in regards to ensuring residents are not receiving unnecessary medications, gradual dose reductions occur where indicated and behavioral interventions are appropriate and careplanned. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee and Pharmacy Consultant will conduct reviews of the resident orders and medication regimen weekly, monthly and at random to ensure that all licensed staff is aware of facility policy regarding GDR and unnecessary medications. The results of the monitoring will be reported to the quarterly QA meetings and action will be implemented as appropriate. The goal will be 90% for the 2nd quarter and 100% for the 3rd quarter.	10/17/16

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4 184	Continued From page 84	4 184	4 184 11-94.1-46(a) Pharmaceutical services See Pages 81-85	10/17/16
4 192	11-94.1-46(i) Pharmaceutical services (i) Appropriately licensed and trained staff shall be responsible for the entire act of medication administration, which entails removing an individual dose from a container properly labeled by a pharmacist or manufacturer (unit dose included), verifying the dosage with the physician's orders, giving the specified dose to the proper resident, and promptly recording the time, route, and dose given to the resident, and signing the record. Only a licensed nurse,	4 192	4 192 11-94.1-46(i) Pharmaceutical services 1. Corrective Action for Resident in Sample: Inservice staff with Rx administration with signatures acknowledging understanding. 2. Identification of other Residents Having the Potential of Being Affected: Unit nurse will offer PRN sleep medication. Unit nurse will ensure that documentation of sleep medication administered includes efficacy.	10/17/16

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4 192	Continued From page 85 physician, or other individual to whom the licensed professional has delegated the responsibility pursuant to chapter 16-89, subchapter 15, may administer medications. This Statute is not met as evidenced by: Based on a complaint, record review and interviews, the facility failed to provide services for a resident to attain the highest practicable psychosocial well-being. Findings include:	4 192	Continued from Page 85 3. Corrective Action/Systemic Changes: If PRN Rx isn't given for a period of 30 days, unit nurse will notify PCP to determine if order should be stopped. All resident records of medication administration will be reviewed to ensure no missing entries. Behavior logs, sleep logs, mood indicators will be audited as well to ensure no missing entries. 4. Monitoring of Corrective Actions to Ensure No Recurrence: Audits will be don daily by RCM, SDC, DON/designees to ensure as indicated. Monitor results will be reported to the QA meeting & necessary actions will be implemented as appropriate. Goal will be 90% 2nd quarter & 100% for 3rd quarter.	10/17/16

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4 192	Continued From page 86	4 192	4 192 11-94.1-46(i) Pharmaceutical services 1. Corrective Action for Resident in Sample: Inservice staff with Rx administration with signatures acknowledging understanding. 2. Identification of other Residents Having the Potential of Being Affected: Unit nurse will offer PRN sleep medication. Unit nurse will ensure that documentation of sleep medication administered includes efficacy. 3. Corrective Action/Systemic Changes: If PRN Rx isn't given for a period of 30 days, unit nurse will notify PCP to determine if order should be stopped. All resident records of medication administration will be reviewed to ensure no missing entries. Behavior logs, sleep logs, mood indicators will be audited as well to ensure no missing entries. 4. Monitoring of Corrective Actions to Ensure No Recurrence: Audits will be don daily by RCM, SDC, DON/designees to ensure as indicated. Monitor results will be reported to the QA meeting & necessary actions will be implemented as appropriate. Goal will be 90% 2nd quarter & 100% for 3rd quarter.	10/17/16

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4 192	Continued From page 87	4 192	4 192 Unnecessary drugs/Comprehensive careplans See Page 86, 87	10/17/16
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 observations, record review, interviews and policy review, the facility failed to establish and maintain: an Infection Control Program under which it investigates, controls and prevents infections in the facility; a record of incidents and corrective actions related to infections; and, a requirement that staff follow handwashing guidelines as indicated by accepted professional practice. Findings include: 1) On 09/16/2016 at 10:45 A.M., interviewed the DON (Director of Nursing) on the facility's Infection Control Program and asked to review	4 203	4 203 11-94.1-53(a) Infection Control See Pages 89-93	10/17/16

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4 203	Continued From page 88 infection control data. The DON was already informed of the lack of hand hygiene during dining and stated that the staff should sanitize the residents hands before dining and CNAs should sanitize hands between residents. Queried DON on whether the facility developed infection control policies and procedures (P&P). The DON stated that the facility was following standard infection control practices and if notices infection trend or cluster would investigate further and perform root cause analysis and provide staff education. She further stated that, DON since June 2016 and on a "learning curve," and working with Staff #17 to build upon the existing infection control program. "If the existing infection control program is working then wouldn't need to change it." When asked what were the immediate plans for the infection control program, the DON replied that her immediate plans were to work with the	4 203	4 203 11-94.1-53(a) Infection Control 1. Corrective Action for Resident in Sample: The DON and SDC met inserviced the licensed staff involved and discussed the facility policy infraction, in regards to infection control with an emphasis on investigation, control, prevention, of infections in the facility; a record of incidents and corrective actions related to infections; and a requirement that staff follow handwashing guidelines as indicated by accepted professional practice. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the licensed staff involved daily,weekly, and at random to ensure compliance of proper investigation, control, prevention of infections in the facility; documentation of the incidents and corrective actions related to infections and proper handwashing by all staff. 3. Corrective Action./Systemic Changes: All licensed staff meeting was conducted to review the facility policy and procedure on infection control, documentation, and handwashing with the emphasis on investigation, prevention and corrective actions related to infections. All licensed staff will be monitored through the use of audits/tools/binders tracking infection control practices, competency and skills to ensure compliance with facility policy and procedure, to ensure no recurrence of the infraction. Inservice education will be ongoing. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee will conduct reviews and observations of licensed staff, audit tools/binders and logs weekly, monthly, and at random to ensure that every licensed staff is in compliance with the facility's guidelines. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. Goal will be 90% for the 2nd Quarter & 100% for the 3rd quarter.	10/17/16

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4 203	Continued From page 89 CNAs and nurses on hand hygiene, peri-care, and MD notification of infections. Queried if the the DON was going to use Center for Disease Control (CDC) and/or World Health Organization (WHO) as a resource to further develop infection control P&Ps and she stated that will probably use WHO since noticing more "international" residents. The DON stated that she was working with nurses on the unit to determine integrity of current infection control program and outcomes. "If there are things that I can do to enhance the infection control program and whether outcomes are beneficial to the resident(s). " When asked to clarify statement the DON stated, "If it's more UTIs or more Respiratory, than that's the pathway I will take. Also looking at the individual's propensity toward infections." The DON further stated, "My hope as the DON is to work with the unit that they are able to collaborate and identify prevailing factors for potential infections and implement whatever is appropriate, (e.g. if Cipro doesn't work would know that cannot use that antibiotic; If lab values don't change, need to collaborate with the doctor if not resolved.)" Queried how the DON was alerted of infections on the units and she stated that at daily "stand-up" meeting and 24 hr summary would alert her of infections going on. The DON also did rounds every AM and PM and talked to residents to check-in if antibiotics working, etc./whatever condition is. Queried the DON on how the facility used records of incidents to improve it's infection control processes and outcomes by taking corrective	4 203	4 203 11-94.1-53(a) Infection Control 1. Corrective Action for Resident in Sample: The DON and SDC met inserviced the licensed staff involved and discussed the facility policy infraction, in regards to infection control with an emphasis on investigation, control, prevention, of infections in the facility; a record of incidents and corrective actions related to infections; and a requirement that staff follow handwashing guidelines as indicated by accepted professional practice. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the licensed staff involved daily,weekly, and at random to ensure compliance of proper investigation, control, prevention of infections in the facility; documentation of the incidents and corrective actions related to infections and proper handwashing by all staff. 3. Corrective Action./Systemic Changes: All licensed staff meeting was conducted to review the facility policy and procedure on infection control, documentation, and handwashing with the emphasis on investigation, prevention and corrective actions related to infections. All licensed staff will be monitored through the use of audits/tools/binders tracking infection control practices, competency and skills to ensure compliance with facility policy and procedure, to ensure no recurrence of the infraction. Inservice education will be ongoing. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee will conduct reviews and observations of licensed staff, audit tools/binders and logs weekly, monthly, and at random to ensure that every licensed staff is in compliance with the facility's guidelines. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. Goal will be 90% for the 2nd Quarter & 100% for the 3rd quarter.	10/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125065	A. BUILDING: ______ B. WING ______	09/19/2016

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4 203	Continued From page 90 action. The DON stated that needs to look at accuracy of data being collected and looking at incidents to improve processes and outcomes but just 3 months on the job and trying to set-up program with new CMs (Case Managers) and new staff, etc. The facility failed to demonstrate that the infection control program has components of an infection prevention and control program which includes data collection, surveillance, planning, organizing, implementing, and monitoring and maintaining all of the elements of the program.	4 203	4 203 11-94.1-53(a) Infection Control 1. Corrective Action for Resident in Sample: The DON and SDC met inserviced the licensed staff involved and discussed the facility policy infraction, in regards to infection control with an emphasis on investigation, control, prevention, of infections in the facility; a record of incidents and corrective actions related to infections; and a requirement that staff follow handwashing guidelines as indicated by accepted professional practice. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the licensed staff involved daily,weekly, and at random to ensure compliance of proper investigation, control, prevention of infections in the facility; documentation of the incidents and corrective actions related to infections and proper handwashing by all staff. 3. Corrective Action./Systemic Changes: All licensed staff meeting was conducted to review the facility policy and procedure on infection control, documentation, and handwashing with the emphasis on investigation, prevention and corrective actions related to infections. All licensed staff will be monitored through the use of audits/tools/binders tracking infection control practices, competency and skills to ensure compliance with facility policy and procedure, to ensure no recurrence of the infraction. Inservice education will be ongoing. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee will conduct reviews and observations of licensed staff, audit tools/binders and logs weekly, monthly, and at random to ensure that every licensed staff is in compliance with the facility's guidelines. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. Goal will be 90% for the 2nd Quarter & 100% for the 3rd quarter.	10/17/16 10/17/16

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4 203	Continued From page 91	4 203	4 203 11-94.1-53(a) Infection Control	
			1. Corrective Action for Resident in Sample: The DON and SDC met inserviced the licensed staff involved and discussed the facility policy infraction, in regards to infection control with an emphasis on investigation, control, prevention, of infections in the facility; a record of incidents and corrective actions related to infections; and a requirement that staff follow handwashing guidelines as indicated by accepted professional practice.	10/17/16
			2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the licensed staff involved daily,weekly, and at random to ensure compliance of proper investigation, control, prevention of infections in the facility; documentation of the incidents and corrective actions related to infections and proper handwashing by all staff.	10/17/16
			3. Corrective Action./Systemic Changes: All licensed staff meeting was conducted to review the facility policy and procedure on infection control, documentation, and handwashing with the emphasis on investigation, prevention and corrective actions related to infections. All licensed staff will be monitored through the use of audits/tools/binders tracking infection control practices, competency and skills to ensure compliance with facility policy and procedure, to ensure no recurrence of the infraction. Inservice education will be ongoing.	
			4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee will conduct reviews and observations of licensed staff, audit tools/binders and logs weekly, monthly, and at random to ensure that every licensed staff is in compliance with the facility's guidelines. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. Goal will be 90% for the 2nd Quarter & 100% for the 3rd quarter.	

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4 203	Continued From page 92	4 203	4 203 11-94.1-53(a) Infection Control	10/17/16

4 203 11-94.1-53(a) Infection Control

1. Corrective Action for Resident in Sample:
The DON and SDC met inserviced the licensed staff involved and discussed the facility policy infraction, in regards to infection control with an emphasis on investigation, control, prevention, of infections in the facility; a record of incidents and corrective actions related to infections; and a requirement that staff follow handwashing guidelines as indicated by accepted professional practice.
2. Identification of Other Resident Having the Potential of Being Affected:
The DON/designee will monitor the licensed staff involved daily,weekly, and at random to ensure compliance of proper investigation, control, prevention of infections in the facility; documentation of the incidents and corrective actions related to infections and proper handwashing by all staff.
3. Corrective Action./Systemic Changes:
All licensed staff meeting was conducted to review the facility policy and procedure on infection control, documentation, and handwashing with the emphasis on investigation, prevention and corrective actions related to infections. All licensed staff will be monitored through the use of audits/tools/binders tracking infection control practices, competency and skills to ensure compliance with facility policy and procedure, to ensure no recurrence of the infraction. Inservice education will be ongoing.
4. Monitoring of Corrective Actions to Ensure No Recurrence:
The DON/designee will conduct reviews and observations of licensed staff, audit tools/binders and logs weekly, monthly, and at random to ensure that every licensed staff is in compliance with the facility's guidelines. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. Goal will be 90% for the 2nd Quarter & 100% for the 3rd quarter.

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4 203	Continued From page 93	4 203	4 203 11-94.1-53(a) Infection Control See Pages 89-93	10/17/16
4 243	11-94.1-64(a) Engineering and maintenance (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:	4 243	F456 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION See Page 95	10/17/16

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4 243	Continued From page 94 During a tour of the facility's rehabilitation services unit on 09/15/2016 at 3:33 P.M., it was observed there were no inspection stickers on certain therapy machines/equipment being used by the residents. These consisted of the Scifit restorator, the Scifit recumbent bike and the Omnicycle. The Rehab Director was queried where the inspection stickers were on the machines, and she stated the equipment was brand new. However, no inspection stickers were found on these machines, nor were any service or tracking logs produced as to the last service or maintenance date and/or future service dates by the vendor/manufacturer. During an interview with the Central Supply and Staffing Coordinator on 09/15/2016 at 3:49 P.M., she stated she made an inventory of all the equipment and ordered the stickers, but had given it to the previous maintenance director. She said she ordered these inspection stickers and the maintenance tags and had the invoices somewhere. There were no invoices of the purchased equipment and there were no inspection stickers found on the rehab equipment to ensure they were being tracked and maintained in safe operating condition.	4 243	F456 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION 1. Corrective Action for Resident in Sample: The DON, NHA met with the staff involved and discussed the facility policy infraction, in regards to maintaining all essential mechanical, electrical, and patient care equipment in safe operating condition. A review of proper inspection stickers, service or tracking logs was also conducted with the emphasis on maintaining these logs to indicate the last service or maintenance date and /or future service dates by the vendor/manufacturer. 2. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the staff involved, daily, weekly, and at random to ensure compliance of proper inspection stickers, service/tracking logs and that the last service date is listed by vendor. 3. Corrective Action/Systemic Changes: All licensed staff meeting was conducted to review the facility policy and procedure for maintaining all essential mechanical, electrical, and patient care equipment . All equipment in therapy suite has been calibrated and labeled with the calibration date. The items included are Scifit Restorator – 9/22/2016; Scifit Recumbent 9/22/2016; Omnicycle 5/2016; Hi/Lo Mat Table 9/22/2016; Hydrocollator 9/22/2016; Parrafin Bath 9/22/2016. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee will conduct observations weekly, monthly and at random to ensure that all essential mechanical, electrical and patient care equipment is in safe operating condition, properly inspected, and tracked with service dates to be in compliance with the facility's policy and guidelines. The results of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate.	10/17/16