Herreii F	Dont of Hoolth Office	o of Hook Ove Assumers			FORM APPROVED
	Dept. of Health, Office NT OF DEFICIENCIES	e of Healt are Assuranc (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		:	COMPLETED
			1		
	ě »	125065	B. WING	DECEIVED	09/19/2016
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE	
LEGACY	HILO REHABILITATION	ON & NITRSING C	AUMANA DRIVI	2016 NOV -2 A 11	: 05
	CUMMA DV CTA	TEMENT OF DEFICIENCIES	HI 96720		
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION SHOULD	
TAG	REGULATORY OR LE	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	PRIATE DATE
				DETIGIENCY)	
4 000	11-94.1 Initial Comr	ments	4 000		
	A State re-licensure	survey was conducted by t	he		
		9/13/16 to 9/16/16. The		,	
	0 3	entrance was 54 residents.			
4 002	11-94.1-2 Definition	s	4 002	4 002 11-94. 1-2 Definitions	10/17/16
	As used in this char	oter:		Corrective Action for Resident in Salaria	ample
				Inservice on 4 002 with staff will on	
		nal" or "qualified therapeution	;	with signatures acknowledging of a	
	recreational special	ist" means:		Activity Coordinator qualifications requirements of job title.	&
	(1) A qualified profe	essional who has two years	of	requirements of job title.	
		ial or recreational program		Identification of other Residents Ha	aving
		ve years, one of which was		the Potential of Being Affected: Activities program is consulted dail	v by
7		nt activities program in a		occupational therapist with approp	
	health care setting			credentials to meet regulatory	
	(2) An occupationa	I therapist or occupational	1	requirements. Documentation of o	
=	therapy assistant;			AD/OT.	led by
	(3) A person who h	as completed a training		Corrective Action/Systemic Change	
	course approved by			Activities Program Director is curre	
				enrolled in classes for regulatory	,
		s eligible for certification as a	a	requirements to be "Activities	
		on specialist or as an ional by a recognized		Professional".	
		or after October 1, 1990.		4. Monitoring of Corrective Actions to	Ensure
	3 7	.,		No Recurrence:	
				Will be monitored in the QA Report quarterly until AD is accredited.	1
			1		

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 Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

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If continuation sheet 1 of 95

are Assuranc Hawaii Dept. of Health, Office of Healt (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 4 002 Continued From page 1 4 002 4 002 11-94. 1-2 Definitions 10/17/16 is a qualified therapeutic recreation specialist or Corrective Action for Resident in Sample: an activities professional who is licensed or Inservice on 4 002 with staff will occur registered, if applicable, by the State in which with signatures acknowledging of an practicing; and is eligible for certification as a Activity Coordinator qualifications & therapeutic recreation specialist or as an activities requirements of job title. professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of Identification of other Residents Having experience in a social or recreational program the Potential of Being Affected: within the last 5 years, 1 of which was full-time in Activities program is consulted daily by a patient activities program in a health care occupational therapist with appropriate credentials to meet regulatory setting; or is a qualified occupational therapist or requirements. Documentation of daily occupational therapy assistant; or has completed meetings and discussion is maintained by a training course approved by the State. AD/OT. Findings include: Corrective Action/Systemic Changes: Activities Program Director is currently Record review of the current Activity Director's enrolled in classes for regulatory (AD) resume and an interview with the AD was requirements to be "Activities done on 09/16/2016 at 9:20 A.M. The AD was Professional". asked what qualified her to be the facility's AD. The AD said she started in her position on or Monitoring of Corrective Actions to Ensure about July 18th or 19th, 2016 and, "I need some No Recurrence: certification to be medical." She said because Will be monitored in the QA Report quarterly until AD is accredited. 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

& Nursing Center's JD for the AD position either. Office of Health Care Assurance STATE FORM

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

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STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED
		125065	B. WING		00/10/2010
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY	STATE, ZIP CODE	09/19/2016
LEGACY	' HILO REHABILITATIO	#00 ICA 11	MANA DRIV		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
4 002	During a discussion the AD requirements regulatory requirements professional," she was requirements were received facility, the nodded and said she AD qualified.	with the NHA who thought so were based on the State ents for "activities as informed if the federal more stringent for a Medicare SA will cite to that. The NHA as will need to get her current	4 002	4 002 Qualifications of Activity Profession See Pages 1, 2	al 10/17/16
	(a) Each facility sha governing body, or of functioning as the overall responsibility activities. The facility administrative manarequirements of this. This Statute is not in Based on observation and review of facility maintain a quality as (QA&A) committee the for the conduct of all maintain methods of to assure the require physician designated demonstrating active QA&A program. In a did not have a quality showed specific standard show the study as processes to better reputcomes, or to preved dentified with respective over the study and show the study as processes to better reputcomes, or to preved dentified with respective standard wit	governing body, that has for the conduct of all y shall maintain methods of gement that assure that the section are met. The section are section are section as a section are met. The section are section are section are section are and are section are secti		1. Corrective Action for Resident in Samp The DON and NHA met with the staff in with QA and discussed the facility policy infraction, in regards to maintaining a assessment and assurance committee of a physician designated by the facility demonstrating active participation in the facility's QA&A. Emphasis is on the conductomes, documentation to show the and improvement of processes to better resident care services and outcomes to prevent/decrease problems identified respect to which quality assessment an assurance activities have been necessate correct identified quality deficiencies. 2. Identification of Other Resident Having Potential of Being Affected: The DON/designee will monitor the licustaff involved, daily, weekly and at rangensure compliance of proper standard quality of care and outcomes. Effective 2016, Ms. Elizabeth Preston, APRN and Norman Goody joined Legacy of Hillo a participate directly with QA to prevent/decrease problems identified respect to quality assessment an assuras necessary to correct deficiencies.	nvolved cy quality consisting y and the mmittee care and e study er o with and dary to the ensed dom, to s for e 10-17- d Dr. nd will with

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		125065	B. WING		09/1	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LEGACY	' HILO REHABILITATIO	ON & NURSING C 563 KAUN HILO, HI	/IANA DRIVI 96720			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
4 088	deficiencies. Findings include: During an interview 09/16/2016 at 11:28 describe the facility has been identified processes or measi she "goes off of CM falls, skin and weigh Upon query as to he policies and procedi process for the care as falls, dementia, v response was they t assessment criteria and implementing it resident outcome. It resident care policy policies which belon which were for Care for Standard Precau policy titles. The fac policies. Cross-refe The SA also asked t QA & A committee in development and im and procedures for it falls. The DON state given to her and at t they become aware then the CNAs hudd the incident reports a causal factors. She placed on a calenda she looked for the fr	with the NHA and DON on a A.M., they were asked to s QA&A program and what as performance improvement ures. The DON initially stated S's indicators," such as pain, at, nutrition, infections, etc. by then their resident care ures outlined a systematic of residents with areas such weight loss, etc., the DON's followed the nursing of identifying it, observing it and evaluating it based on however, a review of the found the facility produced ged to another company, a Planning for Residents and ations, as evidenced by the stility did not have their own rence to F279, F280. The NHA and DON how their nonitored for consistent aplementation of their policies residents specific to falls in ose residents with recurrent ed the incident reports were their daily stand up meeting, of who has fallen. She said then they look at other explained the falls were review and pattern of falls The DON was asked if she	4 088	Continued from Page 3 3. Corrective Action / Systemic Changes: All licensed staff meeting was conducter review the facility QA process with the emphasis on specific standards for qual care and outcomes, documentation of and improvement of processes that be resident care services. Participation by members of the committee will be more ensure compliance and to ensure no resoft the infraction. 4. Monitoring of Corrective Actions to Ensemble 1975. Recurrence: The DON/designee will coordinate with and MD reviews to improve quality of a reas such as Safety, Dining, Infection of Falls to achieve decrease in fall rates. Psychotropic Medication use, Pain, Skin Weights (Nutrition at Risk). Data analy reviews of trends and patterns as well of committee meetings and minutes we done weekly, monthly and at random of facility compliance with QAPI. The resoft the monitoring will be reported to the QA meeting and necessary actions will implemented as appropriate. Goal will Quarter 90% compliance & 3rd Quarter compliance.	lity of the study tter r all nitored to ecurrence sure No n APRN care in Control, n and rsis, as audits rill be to ensure ults on quarterly be lbe 2nd	10/17/16

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Hawaii Dept. of Health, Office of Health re Assuranc STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ 125065 B. WING 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 4 088 11-9431-16(a) Governing body & management 4 088 Continued From page 4 4 088 10/17/16 had documentation for this and replied the charge Corrective Action for Resident in Sample: The DON and NHA met with the staff involved nurses documented it and that they do root cause with QA and discussed the facility policy analysis with their falls committee. infraction, in regards to maintaining a quality Cross-reference to F323. assessment and assurance committee consisting of a physician designated by the facility and When the NHA and DON were asked how their demonstrating active participation in the QA & A committee has provided monitoring and facility's QA&A. Emphasis is on the committee oversight for the care and services for residents having specific standards for quality of care and with falls and the care plan process, as it was one outcomes, documentation to show the study of the areas of concern during the survey, the and improvement of processes to better DON stated for the care plans, with each resident care services and outcomes to prevent/decrease problems identified with intervention, the care plans "are updated. I'm following up, we have a lot of new nurses we're respect to which quality assessment and working with." She also said "staffing vigilance as assurance activities have been necessary to correct identified quality deficiencies. process--as our census has grown, our staffing Identification of Other Resident Having has grown, and that has decreased the number Potential of Being Affected: of falls to date." However, the DON stated she The DON/designee will monitor the licensed "has no trending," for the SA to see. Yet, during staff involved, daily, weekly and at random, to the meeting, the DON said she did have a QA ensure compliance of proper standards for falls binder and stepped out of the meeting to quality of care and outcomes. Effective 10-17look for the falls QA binder. At 11:45 A.M., upon 2016, Ms. Elizabeth Preston, APRN and Dr. her return to the meeting, she said she could not Norman Goody joined Legacy of Hilo and will find the falls binder which had all of her QA falls participate directly with QA to material in it. Cross-reference to F278, F279, prevent/decrease problems identified with respect to quality assessment an assurance and F280, F281. as necessary to correct deficiencies. Corrective Action / Systemic Changes: In addition, the NHA and DON were asked if they All licensed staff meeting was conducted to had identified issues with staffing and resident review the facility QA process with the dining. The SA said dining observations found emphasis on specific standards for quality of periods of time when there was no staff in the care and outcomes, documentation of the study dining room and residents were waiting, and and improvement of processes that better some residents needed full assistance to eat but resident care services. Participation by all were not provided with it. The DON replied, "We members of the committee will be monitored to need more carts. It will look less chaotic and ensure compliance and to ensure no recurrence they'll be more individuals assisting. Right now I of the infraction. have meals being wheeled in and 2 carts, so I Monitoring of Corrective Actions to Ensure No need to have more staff to feed." The DON was Recurrence: The DON/designee will coordinate with APRN asked about the RNA dining program and how

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the program was being implemented and

monitored. She stated, "I'll be observing and

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and MD reviews to improve quality of care in

areas such as Safety, Dining, Infection Control,

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%

Falls to achieve decrease in fall rates.

compliance.

on sheet 5 of 95

PHINIED: 10/10/2016 FORM APPROVED Hawaii Dept. of Health, Office of Health are Assuranc STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: (B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 4 088 11-9431-16(a) Governing body & management 4 088 Continued From page 5 4 088 10/17/16 checking with (RNA Nurse) to see if the resident Corrective Action for Resident in Sample: is increasing their level of participation with self The DON and NHA met with the staff involved feeding." Then she was asked, what if the with QA and discussed the facility policy infraction, in regards to maintaining a quality resident had weight loss, and her response was, assessment and assurance committee consisting "Then we have to re-evaluate what we're doing of a physician designated by the facility and and get the dietitian to help me." She stated the demonstrating active participation in the Nutrition at Risk committee meets weekly and facility's QA&A. Emphasis is on the committee they have identified those residents and they "do having specific standards for quality of care and a new assessment and the monitoring of it and outcomes, documentation to show the study we track what's happening with the individual." and improvement of processes to better For a resident who has had significant weight resident care services and outcomes to loss, the DON said documentation would be prevent/decrease problems identified with found in the PCC (their electronic health record respect to which quality assessment and system) and "it's under nutrition risk," which assurance activities have been necessary to tracks the resident's weights. correct identified quality deficiencies. Identification of Other Resident Having the Potential of Being Affected: Related to facility staffing concerns and with so The DON/designee will monitor the licensed many new hire nurses, they were asked how the staff involved, daily, weekly and at random, to QA&A committee may have identified any quality ensure compliance of proper standards for deficiency areas related to the care of residents quality of care and outcomes. Effective 10-17as a means for improvement, including the tools 2016, Ms. Elizabeth Preston, APRN and Dr. used to monitor that residents are getting the Norman Goody joined Legacy of Hilo and will provision of care and services in some of the participate directly with QA to identified areas such as fall prevention, care prevent/decrease problems identified with planning, dining service and assistance, weight respect to quality assessment an assurance and loss monitoring, etc. The DON stated it was done as necessary to correct deficiencies. by providing education, whether of the staff or Corrective Action / Systemic Changes: All licensed staff meeting was conducted to educating families, monthly inservices and by doing "daily huddles" where they discussed what review the facility QA process with the emphasis on specific standards for quality of was going on with individuals and residents and care and outcomes, documentation of the study the separate shifts. and improvement of processes that better resident care services. Participation by all As to the staffing concerns, the DON said, "Some members of the committee will be monitored to

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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

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Psychotropic Medication use, Pain, Skin and ion sheet 6 of 95 Weights (Nutrition at Risk). Data analysis,

ensure compliance and to ensure no recurrence

Monitoring of Corrective Actions to Ensure No

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.

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%

of the infraction.

Recurrence:

compliance.

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STATEME	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T (X2) MULTIF	PLE CONSTRUCTION	(VO) DATI	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE		
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		HILO, HI		_		
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Ina	HEGOENION ON E	SCIDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AI	PPROPRIATE	DATE
				DEFICIENCY)	<u> </u>	
4 088	Continued From pag	.ge 6	4 088	4 088 11-9431-16(a) Governing body	& management	
!	problem the NHA s	said that same nearly any they				10/17/16
1	"need more rehab."	said that some people say they The DON said also that the		Corrective Action for Resident in	n Sample:	
1	food conved was co	The DON said also that the		The DON and NHA met with the	staff involved	
1	1000 Serveu was cor	old on occasion, with some		with QA and discussed the facilit	ty policy	
	residents wanting in	nore ethnic dishes and more		infraction, in regards to maintain	ning a quality	
J	avocados. You're ri	ight I haven't written it down,"	1	assessment and assurance comm		
1	was the response to	o the SA. Cross-reference to	1	of a physician designated by the	facility and	
1	F353.	J	1	demonstrating active participation		1
1	1	,		facility's QA&A. Emphasis is on t		
	1	J	1	having specific standards for qua		ĺ
	1	J	1	outcomes, documentation to sho		ĺ
	i	J	<i>i</i> '	and improvement of processes to		ĺ
	I	J	<i>i</i> '	resident care services and outcome		i
	I	1	1	prevent/decrease problems iden		i
	i	1	<i>i</i>	respect to which quality assessm		i
	i	I	, !	assurance activities have been no		i
,		1		correct identified quality deficier		i
			1	 Identification of Other Resident H Potential of Being Affected: 	aving the	
		-	ı	The DON/designee will monitor t		
	They were asked if the	they could provide the SA with		staff involved, daily, weekly and a		
	any other QA & A act	tivities/programs they have		ensure compliance of proper star		
	implemented for prod	cess improvement. Their		quality of care and outcomes. Ef		
	collective response w	was that they just got a skin	1	2016, Ms. Elizabeth Preston, APR	(N and Dr.	
	nurse and the other of	care manager is a wound		Norman Goody joined Legacy of I	Hilo and will	
	certified nurse.	All of the langer to a trout, a		participate directly with QA to		
		1		prevent/decrease problems ident		
1	On 09/16/2016 at 12	:44 P.M., Staff #2 brought		respect to quality assessment an		
1	the OA falls binder w	hich she said she got from		as necessary to correct deficienci	ies.	
	the DON to give to a	CURVOYOR Stoff #0		Corrective Action / Systemic Chan		
1,	confirmed this is the	only binder of falls and she	1	All licensed staff meeting was cor		
l i	had worked on alpha	only binder of falls and she	1	review the facility QA process wit		
;	fall rolated incident re	betizing all of the resident	1	emphasis on specific standards fo		
1;	atotad during the inte	eports. Although the DON		care and outcomes, documentation		
	stated during the inter	erview they have had a	1	and improvement of processes th		
	Jecrease in the numb	ber of falls by having had		resident care services. Participati		
["	ncreased statt, the la	ast fall meeting of 9/7/16		members of the committee will be		
!!	ncluded signatures or	of four licensed staff plus the		ensure compliance and to ensure	no recurrence	
L	DON and the topics of	of discussion included		of the infraction.		
ir	implementing fall mats	ts for two residents, possibly		Monitoring of Corrective Actions to	to Ensure No	
n	moving one resident to	to a closer room or add a		Recurrence:	tol- ammai	
r	roommate and implen	menting a "fall checklist.		The DON/designee will coordinate		
"	There was no other of	data to indicate how the		and MD reviews to improve qualit areas such as Safety, Dining, Infec		
		70000 10 7700000 11077 110	I	areas such as Sarety, Dining, intec	tion Control,	

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Falls to achieve decrease in fall rates.

compliance.

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%

on sheet 7 of 95

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FORM APPROVED Hawaii Dept. of Health, Office of Health are Assuranc STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING _ 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 4 088 Continued From page 7 4 088 4088 11-9431-16(a) Governing body & management 10/17/16 See Pages 3-7 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. 4 115 11-94.1-27(4) Resident rights and facility 4 115 11-94.1-27(4) Resident rights and facility 4 115 10/17/16 Practices practices Corrective Action for Resident in Sample: Written policies regarding the rights and Education on 4 115 with staff will occur with

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

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signatures acknowledging understanding of

addressing distance of resident to meal tray

Identification of other Residents Having the

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

has begun to enhance dining experience,

promote dignity.

daily.

Potential of Being Affected:

infraction. Correct feeding techniques

Hawaii Dept. of Health, Office of Health are Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING _ 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 4 115 Continued From page 8 4 115 Continued from Page 8 10/17/16 Corrective Action/Systemic Changes: the facility for four residents Compliance with meal service assist will be of the 38 residents in the sample. documented daily as Dining room observations, discuss monthly at Dining Findings include: 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. 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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09/19/2016

Hawaii Dept. of Health, Office of Health, are Assurance STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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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
4 115	Continued From page 9		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

Hawaii Dept. of Health, Office of Health re Assuranc STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING _ 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 4 115 4 115 11-94.1-27(4) Resident rights and facility 4 115 Continued From page 10 10/17/16 Practices 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. 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. 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. 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 2^{nd} quarter and 100% for the 3^{rd} quarter.

Office of Health Care Assurance

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09/19/2016

Hawaii Dept. of Health, Office of Health. Are Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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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	10/17/16
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			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 2 nd quarter and 100% for the 3 rd quarter.	
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PRINTED: 10/10/2016

FORM APPROVED Hawaii Dept. of Health, Office of Health, are Assuranc STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING _ 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 4 115 4 115 11-94.1-27(4) Resident rights and facility 4 115 Continued From page 12 10/17/16 Practices 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. 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. 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. 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.

Hawaii Dept. of Health, Office of Health, are Assurance STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _____ B. WING ___ 125065 09/19/2016

NAME OF PROVIDER OR SUPPLIER

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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	4 130	4130 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.		Corrective Action for Resident in Sample: Education inservice on 4 130 with staff will occur with signatures acknowledging understanding of Event Reporting of Incidents. 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	
	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		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.	

Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
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4 130	Finding includes: A review of "Event If facility to the State A submitted from 11/2 reports were related origin; and alleged a "Abuse Prevention I A.M. A review of the section entitled "Refacility did not includivolations and all su State Agency. An ir Nursing Home Adm of Nursing (DON) or NHA and DON were facility's policy did not including the section of the section entitled "Refacility did not include the section of the section entitled".	Reports" completed by the Agency found reports were 24/15 through 7/19/16. The d to falls; injuries of unknown abuse by a family member. acility provided a copy of the Program" on 9/16/16 at 8:34 e facility's policy found in the porting/Response" that the de reporting all alleged bstantiated incidents to the nterview was done with the inistrator (NHA) and Director 19/16/16 at 12:45 P.M. The e agreeable that the the ot include procedures to	4 130	Continued from Page 14 3. Corrective Action/Systemic Changes: Compliance with timely and accurate reporting will be monitored daily with up meeting discussion of prior 24 hour facility review of orders for that day, results of all investigations shall be reto the Administrator of the facility or designated representative and to oth officials, including the department in accordance with the State Law within working days of the incident. 4. Monitoring of Corrective Actions to E No Recurrence: Results of this monitoring will be included and the provided and the	event n stand urs for The ported the er 5 nsure
	incidents to the Stat	plations and all substantiated e Agency.		4 134 11-94.1-29(e) Resident abuse, neglect, Misappropriation	and .
4 134	misappropriation (e) The results of a reported to the admithe designated in officials, including the accordance with days of the incident.	n state law within five working	4 134	1. Corrective Action for Resident in S. Education inservice on 4 130 with a occur with signatures acknowledging understanding of Event Reporting of Incidents. 2. Identification of Other Residents Has Potential of Being Affected: Unit nurses, nurse aides have been on event reporting for altercations are elopement; signatures acknowledge understanding. Other residents at relopement/abuse will be identified falls, safety, pain and nutrition at ris	staff will ing of aving the educated as well as isk for through
	Based on record rev	net as evidenced by: riew and interview with staff y failed to ensure all alleged		committee meetings as well as Gran rounds/Focus rounds done by NHA/ DON/designee, SDC, RSM.	d ·

Hawaii Dept. of Health, Office of Health C Assuranc (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ B. WING _ 09/19/2016 125065

NAME OF PROVIDER OR SUPPLIER

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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:	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
	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.			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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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	10/17/10
4 136	11-94.1-30 Resident care	4 136	4 136 11-94. 1-30 Resident Care See Page 18	10/17/10
	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 			A THE STATE OF THE
	(8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth.	٠		
	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			

FORM APPROVED Hawaii Dept. of Health, Office of Health. are Assuranc STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING _ 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) 4 136 Continued From page 17 4 136 4 136 11-94. 1-30 Resident Care 10/17/16 and maintain the highest practicable health and Corrective action for Residents in Sample: medical status, including but not limited to the The DON, NHA and SDC met with licensed administration and tracking of influenza and staff and discussed the facility policy pneumococcal immunizations for the residents. infraction, in regards to proper tracking of pneumococcal and influenza 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

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.

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.

- 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.
- 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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NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STATE, ZIP CODE	
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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) COMPLET DATE
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. 11-94.1-38(a) Activities	4 136	4 136 11-94. 1-30 Resident Care See Page 18 4 145 11-94. 1-38(a) Activities	10/17/16
	(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:		 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. 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. 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. 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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PRINTED: 10/10/2016 Hawaii Dept. of Health, Office of Health are Assuranc (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 4 145 Continued From page 19 4 145 10/17/16 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. 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. 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. 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 4 148 4 148 11-94.1-39(a) Nursing Services Corrective Action for Resident in Sample: (a) Each facility shall have nursing staff sufficient The DON, NHA and SDC met with licensed in number and qualifications to meet the nursing staff involved and discussed the facility needs of the residents. There shall be at policy infraction, in regards to insufficient least one registered nurse at work full-time on the staff, providing proper training and shift, for eight consecutive hours, seven knowledge in the care plans of each days a week, and at least one licensed nurse at Resident to achieve the highest practicable work on the evening and night shifts, unless physical, mental and psychosocial well otherwise determined by the department. being; the development of careplanning

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This Statute is not met as evidenced by:

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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.

policy as a basis for comprehensive assessments to ensure each residents needs

are identified and met through care planning goals and outcome

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Hawaii Dept. of Health, Office of Health Jare Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ 125065 09/19/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE **DEFICIENCY**) 4 148 Continued From page 20 4 148 10/17/16 Continued from Page 20 Identification of other Resident Having the Based on observations, record reviews, Potential of Being Affected: interviews, and facility policy review, the facility The DON/designee will monitor the staff failed to provide nursing staff sufficient in number involved daily, weekly and at random to and qualifications to meet the nursing needs of ensure orientation includes competency the residents. This was evidenced by the staff's skills check lists prior to placement on the inability to provide needed care to residents to units; shadowing of staff for orientation enable the residents to reach their highest includes training in care planning, resident practicable physical, mental and psychosocial preferences and individual needs. well-being and includes the cumulative findings in Corrective and Systemic Changes: the cited areas stated below. All licensed staff meeting was conducted to review the facility policy and procedure for hiring and training of new personnel, with Findings include: the emphasis on ensuring knowledge of the uniqueness of each individual resident and 1. Interviews with residents, family members and their individualized plan of care and to staff validated the lack of the delivery of ensure no recurrence of infraction. necessary provision of care and services to the Monitoring of Corrective Actions to Ensure residents at this facility. There is also the failure No Recurrence: by administration to ensure their staff are trained The DON/designee will conduct audits and and knowledgeable in the care plans of each observation of licensed staff daily, weekly, resident to be able to deliver the individualized monthly and at random to ensure that care required to achieve the highest practicable every licensed staff is competent and physical, mental and psychosocial well-being for capable of providing individualized quality each resident, current and/or discharged. Again, care to Residents to enable the Resident to achieve and maintain their highest level of this was not found as evidenced by the deficient wellbeing. The results of the monitoring will practices found in each citation at 4088, 4115. be reported to the quarterly QA meeting 4130, 4134, 4136, 4145, 4149, 4152, 4153, 4154, and necessary actions will be implemented 4174, 4175, 4184 and 4203. Moreover, the as appropriate. Data analysis and trends facility did not have its own developed policy for will be monitored by QAPI, 3rd Friday at care planning, which is the basis by which 8am, once per month. comprehensive assessments are formulated to ensure each resident's care needs are identified and met through outlined care planning goals and outcome measurements. 10/17/16 4 149 11-94.1-39(b) Nursing services 4 149 4 149 11-94.1-39(b) Nursing Services See Page 22 (b) Nursing services shall include but are not limited to the following:

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4 149	Continued From pag	ge 21	4 149			ction for Resident in Sample	
	(1) A comprehensiv	e nursing assessment of				IA and SDC met with the	10/17/16
	each resident and th	e development and	:			f involved and discussed the	1
	implementation	of a plan of annual ill in fi				infraction, in regards to	
	days of admission	of a plan of care within five	1			the resident environment	
	chall be developed :	The nursing plan of care		1		ee of accident hazards as is	
	shall be developed in	n conjunction with the		1		each resident receives pervision and assistance	
	priysician's admissio	n physical examination and				event accidents. A review o	ا ء
	initial orders. A nurs	ing plan of care shall be				otocol and guidelines was a	
- 1	integrated with an	overall plan of care			conducted w	ith licensed staff with the	150
	developed by an inte	rdisciplinary team no later	1			care plans and fall risk	
	than the twenty-first	day after, or simultaneously,	1			indications of whether the	
	with the initial interdis	sciplinary care plan				evel I or Level II fall risk,	
	conference;					specific to the careplan as	1
					preventive fa	Il recurrence measures.	
	(2) Written nursi	ing observations and	1			of Other Resident Having th	ne l
	summaries of the res	sident's status recorded, as				eing Affected:	_
1	appropriate, due	to changes in the resident's				ignee will monitor the licens	sed
	condition, but no less	than quarterly; and	1	ļ	staff involved	, daily, weekly and at randor	m
	,	qualitariy, and	1	1		pliance with proper fall poli	
	(3) Ongoing eva	luation and monitoring of	l		and safety pro		
	direct care staff to en	sure quality resident care		9	. Corrective Act	tions/Systemic changes:	
- 1	is provided.	oure quality resident care				ng was conducted to review	,
İ	io provided.					licy of falls and safety	
				Ì		the emphasis on preventiv	
	This Statuta is not m	et en avidan i 11				eplan interventions and roo	
	This Statute is not m	et as evidenced by:				. Restorative Nursing, Rehal	
	intensions and a serior	n, record review, staff				lurse, and aides will 'huddle'	
	interviews and a revie	w of the facility's policy, the				th resident the circumstance	es
	acility did not ensure	the resident's environment				ne event. User defined	
[]	remained free of acci-	dent hazards and that each			assessments s	uch as Falls, Skin, Pain will b	e
1	resident receives ade	quate supervision and				well as careplan updated an	d
1	assistive devices to p	revent accidents for 7				oted. All instances will be	
						ensure compliance with	
	of 38 residents	reviewed for accidents, and				nd to ensure no recurrence	
f	alled to demonstrate	ongoing evaluation and			of the infractio		
r	nonitoring of direct ca	are staff to ensure quality		4.		Corrective Actions to Ensure	2
r	esident care is provid	led. As a result one			No Recurrence		
r	esident sustained ski	n wounds to his forearms				/designee will conduct	
v	vithout a documented	fall, other residents have	J			observations of Falls events	j
l i	ad multiple falls but	vithout updated care plans				nonthly and at random to	
	r falls risk seeseeme	ots implements de la care plans				ery licensed staff is in	
	esident had the set-	nts implemented, one				h facility's policy for Falls	
of 11= 12	Come According to poten	tial for choking and one				tion. Tracking of pertinent	
	Care Assurance					and associated changes	
E FORM		6	899 PI	HLE	with carepians	will be audited and	ation sheet 22 of 0

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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 2^{nd} quarter & 100%compliance in the 3rd quarter.

(X5) COMPLETE DATE

10/17/16

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 149	Continued From paresident with elopin hitting other resider Findings include:	g/wandering behavior and	4 149	The DON, NHA and SDC met with t involved and discussed the facility infraction, in regards to compreher assessments, development of com careplans, cross reference to unne drugs and their right to participate careplanning with an emphasis on coding, collaboration with Rehab for GG, review of medication regiment residents' right to participate with careplanning. 2. Identification of Other Resident Has Potential of Being Affected: The DON/designee will monitor the staff weekly and at random to ensucompliance with proper coding of for limitations in ROM, that Medication appropriate for usage with PRNs' documented as well as behavioral a completed; all residents will have competed; all residents will have competed; all residents will have competed; all residents will be unreflect measurable and realistic good designed to achieve the highest president of function. 3. Corrective and Systemic Changes: All licensed staff meeting as condunce with facility policy and proce comprehensive assessments, caregurancessary medication and partic with Careplanning. The emphasis is accurate assessments, individualized careplans, discontinuance of unnecessary medication.	the staff policy nsive prehensive cessary in accuracy in or Section s, and the aving the e involved ure functional ns are logs careplan eir updated to als acticable cted, to dure for olans, cipation s on ed

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medications, participation with careplanning and attendance at meetings. The MDS and

Monitoring of Corrective Actions to Ensure

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

RAI will drive the process.

No Recurrence:

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FORM APPROVED Hawaii Dept. of Health, Office of Health, are Assuranc STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 4 149 Continued From page 23 4 149 4 149 11-94.1-39(b) Nursing services 10/17/16 Corrective Action for Resident in Sample: Prevention policy as it did not indicate whether The DON, NHA and SDC met with the staff the resident was a Level I or Level II fall risk. 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. 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

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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

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

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.

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Monitoring of Corrective Actions to Ensure

The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan administrative overview weekly, monthly and

level of function.

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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

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Hawaii Dept. of Health, Office of Health ~e Assuranc (X1) PROVIDE JUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEEICIENCY 4 149 11-94.1-39(b) Nursing services 4 149 Continued From page 25 Corrective Action for Resident in Sample: 4 149 10/17/16 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. 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. 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. 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

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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

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					and attendance at meetings. The		
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of Health	Care Assurance				the medication administration pro		
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			Pl	HL.	and documentation of the effective PRN and scheduled medications. The		n sheet

of the monitoring will be reported to the quarterly QA meeting and necessary actions will be implemented as appropriate. The $2^{\mbox{\tiny nd}}$ quarter goal is 90% and the 3^{rd} quarter goal is

Hawaii Dept. of Health, Office of Health, are Assurance STATEMENT OF DEFICIENCIES PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG 4 149 11-94.1-39(b) Nursing services Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff 4 149 Continued From page 27 4 149 10/17/16 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. 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. 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

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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

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Hawaii Dept. of Health, Office of Health Jare Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED 125065 B. WING 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG 4 149 11-94.1-39(b) Nursing services DATE Corrective Action for Resident in Sample: 4 149 Continued From page 28 The DON, NHA and SDC met with the staff 4 149 10/17/16 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. Corrective and Systemic Changes: 3. 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. 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; Office of Health Care Assurance completion of appropriate behavioral logs

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quarterly QA meeting and necessary actions will be implemented as appropriate. The 2^{nd} quarter goal is 90% and the 3^{nd} quarter goal is

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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

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				completed; all residents wil	l have careplan	
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				RAI will drive the process.	. He INDS and	
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				guidelines for assessment, car	replanning and	
ffice of Healt	h Care Assurance			the medication administration completion of appropriate be	n protocol;	
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Hawaii Dept. of Health, Office of Health, are Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE 4 149 11-94.1-39(b) Nursing services Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff 4 149 Continued From page 34 4 149 10/17/16 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. 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. 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. 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 Office of Health Care Assurance and documentation of the effectiveness of STATE FORM 6899 PHLI ion sheet 35 of 95 PRN and scheduled medications. The results

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PRN and scheduled medications. The results tion sheet 36 of 95

Hawaii Dept. of Health, Office of Health, Jare Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ 125065 B. WING 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE ED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 4 149 11-94.1-39(b) Nursing services Corrective Action for Resident in Sample: 4 149 Continued From page 36 4 149 The DON, NHA and SDC met with the staff 10/17/16 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. 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. 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. 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; Office of Health Care Assurance completion of appropriate behavioral logs STATE FORM and documentation of the effectiveness of 6899 PHLI ion sheet 37 of 95

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING _ 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE 4149 11-94.1-39(b) Nursing services Corrective Action for Resident in Sample: 4 149 Continued From page 37 4 149 The DON, NHA and SDC met with the staff 10/17/16 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. 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. 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. 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: Office of Health Care Assurance completion of appropriate behavioral logs STATE FORM 6899 and documentation of the effectiveness of PHL ion sheet 38 of 95 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

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Hawaii Dept. of Health, Office of Health Jare Assurance

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 563 KAUMANA DRIVE **LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DESECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 4 149 11-94.1-39(b) Nursing Services TAG TAG DATE Corrective Action for Resident in Sample: The DON, NHA and SDC met with the 4 149 Continued From page 38 4 149 licensed staff involved and discussed the 10/17/16 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. 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. 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. 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 Office of Health Care Assurance incorporated with QAPI for monitoring STATE FORM 6899 effectiveness of the preventive measures in sheet 39 of 95 PHLB11 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.

Hawaii Dept. of Health, Office of Health Care Assurance

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				facility policy infraction, in rega		
				ensuring that the resident envir		
				remains as free of accident haz		
				possible; and each resident reco		
				adequate supervision and assist	ance	
				devices to prevent accidents. A		
				proper fall protocol and guidelin		
				conducted with licensed staff w		
				emphasis on care plans and fall		
				assessments; indications of whe resident is a Level I or Level II fa		
				interventions specific to the can		
				preventive fall recurrence meas		
				Identification of Other Resident		
				Potential of Being Affected:		
				The DON/designee will monitor	the licensed	
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				to ensure compliance with prop	er fall policy	
				and safety protocols.		
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				the facility policy of falls and saf protocols with the emphasis on		
				measures, careplan intervention		
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				services and Nurse, and aides wi	4.	
				and discuss with resident the cir	cumstances	
1				surrounding the event. User def		
				assessments such as Falls, Skin, I		
				completed as well as careplan up		
				intervention noted. All instances		
				monitored to ensure compliance		
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				Monitoring of Corrective Action:	to Ensure	
				No Recurrence:	TO ETIONE	
				The DON/NHA/designee will con	duct	
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				daily, weekly, monthly and at rar	dom to	
				ensure that every licensed staff i		
				compliance with facility's policy f		
				and Fall Prevention. Tracking of p		
1				documentation and associated ci	nanges	

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with careplans will be audited and

incorporated with QAPI for monitoring

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.

effectiveness of the preventive measures ation sheet 40 of 95

Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 PROVIDER'S PLAN OF CORRECTION
ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX 4149 11-94.1-39(b) Nursing services TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff 4 149 Continued From page 40 4 149 involved and discussed the facility policy 10/17/16 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. 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. 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. 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

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100%

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ion sheet 41 of 95

the medication administration protocol; completion of appropriate behavioral logs

and documentation of the effectiveness of

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

PRN and scheduled medications. The results

Hawaii Dept. of Health, Office of Health, are Assuranc

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STATEMENT OF DEFICIENCIES	(
AND PLAN OF CORRECTION	

X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2)	MULTIPLE	CONSTRUCTION	
А. В	UILDING:		

(X3) DATE SURVEY COMPLETED

125065

B. WING

09/19/2016

(X5) COMPLETE DATE

10/17/16

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEGACY	HILO REHABILITATION & NURSING C HILO, HI	IANA DRIVE 96720	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDED BY AN OF CORRECTION 11-94. 1-39(e) Nursing services 1. Corrective Action for Resident in Sample: The DON and SDCs discussed with the
4 152	Continued From page 41	4 152	licensed staff involved and discussed the facility policy infraction, in regards to failing
4 152	(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	4 152	tacility 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 administrative time, 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.
	professional standards of practice, including medication or drug administration procedures that		No Recurrence: The DON/designee and the Pharmacy
	clearly define drug administration process and documentation for 1 of 38 residents		consultant will conduct medication administration observations with licensed staff weekly, monthly and at random to
Office of Heal	th Care Assurance		ensure that licensed staff is in compliance

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with the facility's medication administration ion sheet 42 of 95 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%.

Hawaii Dept. of Health, Office of Health Jare Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 125065 B. WING 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 4 152 11-94. 1-39(e) Nursing services PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) Corrective Action for Resident in Sample: TAG TAG DATE The DON and SDCs discussed with the licensed staff involved and discussed the 4 152 | Continued From page 42 4 152 facility policy infraction, in regards to failing 10/17/16 to maintain professional standards of reviewed. conduct when making changes to medication schedules, notifying the Findings include: 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. 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. 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. 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 Office of Health Care Assurance with the facility's medication administration STATE FORM PHLB guidelines and have referenced the in sheet 43 of 95 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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TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG		1.			DATE
				_		The DON and SDCs discusssed wi licensed staff involved and discus		
4 152	Continued From page	ge 43	4 152			facility policy infraction, in regard		10/17/16
						to maintain professional standard	_	
						conduct when making changes to	1	
						medication schedules, notifying t		
						physician in a timely manner for t		
						clarification on medication admin		
						time. A review of proper medicat administration guidelines was als		
						conducted with the involved staff		
						emphasis on the residents' prefer	ence,	
						documentation and notification to	o the	
						physician of the medication admi		
						time change, and involvement of		
					2.	pharmaceutical representative as Identification of Other Resident H		
					۷.	Potential of Being Affected:	aving the	
						The DON /designee will monitor t	he	
						licensed staff involved weekly, an	d at	
Ì						random to ensure compliance of p	oroper	,
						medication administration proced		
						that residents are receiving medic		
						preferred times and that the phys aware of and in agreement with n		
						administrative times.	realcation	
					3.	Corrective Action/Systemic Change	ges:	
						All licensed staff meeting was cor	ducted,	
						to review the facility medication		
						administration policy and procedu		
						the emphasis on ensuring the resi comfortable with the administrati	1	
						the medication will be of therape	,	
						at the preferred time and that the		
1						is aware of the administrative time	e. All	
						licensed staff will be monitored du	_	
						medication administration proced	- 1	
						ensure compliance with guidelines residents' satisfaction and to ensu		
			*			residents satisfaction and to ensu		
					4.	Monitoring of Corrective Actions t		
						No Recurrence:		
						The DON/designee and the Pharm	•	
						consultant will conduct medication		
-						administration observations with I		1
						staff weekly, monthly and at rando ensure that licensed staff is in com		İ
ffice of Healt	h Care Assurance					with the facility's medication admi		
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		,	·			residents' preferred time, have det		

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 2^{nd} quarter is 90 % and for the 3^{rd} quarter, 100%.

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3:	(X3) DATE COMP	SURVEY
		125065	B. WING		09/1	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	-	
LEGACY	HILO REHABILITATION	ON & NURSING C 563 KAU HILO, HI	MANA DRIV	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
4 152	Continued From page	qe 44	4 152	4 152 11-94. 1-39(e) Nursing services See Pages 42-45		10/17/16
	residents shall be m well-balanced diet recommended dietal and Nutrition Board (Council, and shall be activity, and disability (1) At least threat regular times with hour span between a and breakfast on the (2) Between meals a consistent with the reoffered routinely and	atritional needs of the et through a nourishing, in accordance with the ry allowances of the Food of the National Research e adjusted for age, sex, y. The meals shall be served daily not more than a fourteen a substantial evening meal following day;	4 153	1. Corrective Action for Resident in State The DON and NHA met with license involved and discussed the facility infraction, in regards to food palata and providing evidence of food hold temperatures on the steam table. A review of proper food holding temperatures and palatability of for fluids was also conducted with this with the emphasis on keeping the free temperature of food items within goand providing food and fluids that a nutritive in value, flavor and appears food that is palatable, attractive and proper temperature. 2. Identification of Other Resident Have Potential of Being Affected: The DON/designee will monitor state involved, daily, weekly, monthly and random, to ensure compliance with food holding temperature and with	ed staff ability Iding ood and staff nolding guidelines are rance; d at the wing the ff d at proper	

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(3) Appropriate substitution of foods shall be

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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.

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PRINTED: 10/10/2016 FORM APPROVED Hawaii Dept. of Health, Office of Health Jare Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 4 153 Continued From page 45 4 153 10/17/16 Continued from Page 45 promptly offered to all residents as necessary; Corrective Action/Systemic Changes: All licensed staff meeting was conducted to review the facility policy and procedure for (4) Food shall be served in a form consistent food temperature and food/fluid with the needs of the resident and the palatability with the emphasis on the resident's ability to consume it; resident's preference and taste. The DSM will maintain a log indicating the (5) Food shall be served with appropriate temperature of the food as it is holding on utensils: the steam table. Other audit tools include Dining Room observations and Dining Room (6) Residents needing special equipment, Coordinator which will engage residents in implements, or utensils to assist them when the assessing of temperature and eating shall have the items provided by the palatability and to ensure no recurrence of facility; and the infraction. Monitoring of Corrective Action to Ensure (7) There shall be a sufficient number of No Recurrence: The DON or designee will conduct audits of competent personnel to fulfill the food and the audit logs/binders/tools in Kitchen and nutrition needs of residents. Paid feeding Dining room as well as observation, daily, attendants shall be trained as per the weekly, monthly and at random to ensure state-approved training protocol. that food temperature, palatability and flavor is in compliance with facility guidelines and measured by residents as This Statute is not met as evidenced by: satisfactory; the results of the monitoring Based on observations, staff interviews and EMR will be reported to the quarterly QA reviews the facility failed to offer food substitutes meeting and necessary actions will be of similar nutritive value for 1 of 38 residents implemented as appropriate. QA goal will be 90% compliance in the 2^{nd} quarter & reviewed, and who refused pureed food. 100% compliance in the 3rd quarter. Findings include:

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF		RUCTION		E SURVEY IPLETED
			7. BOILDING	o			
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TAG		SC IDENTIFYING INFORMATION)	TAG	4 153 1 1.	1-94. 1-40(a) Dietary Services Corrective Action for Resident in S	iample:	DATE
4 153	Continued From pa	ne 46	4 153	+-	The DON and NHA met with licens involved and discussed the facility		1
4 100	Continued From pa	g e 40	4 155		infraction, in regards to food palat		10/17/16
					and providing evidence of food ho	_	ı
					temperatures on the steam table.		
			1		A review of proper food holding temperatures and palatability of fo	ood and	
			1		fluids was also conducted with this		
					with the emphasis on keeping the		
					temperature of food items within	guidelines	
					and providing food and fluids that		
			ļ		nutritive in value, flavor and appear		
					food that is palatable, attractive as proper temperature.	nd at the	
			1	2.		aving the	
					Potential of Being Affected:		
					The DON/designee will monitor st	aff	
			i		involved, daily, weekly, monthly a		
					random, to ensure compliance wit		
1					food holding temperature and wit providing food/fluid that is palatal		
					attractive and at the proper temper		
					Interviews with residents on a rand		
					basis, a minimum of 5 per week, to	0	
					ascertain palatability is ongoing an		-
					as a basis for gaining consensus re	garding	
					menu changes. Corrective Action/Systemic Change		
				3.	All licensed staff meeting was cond		
					review the facility policy and proce		
					food temperature and food/fluid		
					palatability with the emphasis on t		
					resident's preference and taste. Th	ne DSM	
					will maintain a log indicating the	lding on	•
					temperature of the food as it is ho the steam table. Other audit tools	-	
				}	Dining Room observations and Din		d d
					Coordinator which will engage resi	-	
					the assessing of temperature and		
					palatability and to ensure no recur	rence of	
				١.	the infraction.	5	
				4.	Monitoring of Corrective Action to	Ensure	
					No Recurrence: The DON or designee will conduct	audits of	
					the audit logs/binders/tools in Kito		
					Dining room as well as observation		
ffice of Heal	th Care Assurance		· ·		weekly, monthly and at random to		
TATE FORM	and the second s		6899	PHLB1	that food temperature, palatability	and	on sheet 47 of 98

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on sheet 47 of 95

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.

<u>Hawaii</u>	Dept. of Health, Office	ce of Health Care Assuranc			FORM APPROV
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY
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4 153	Continued From page	ge 47	4 153	4 153 11-94. 1-40(a) Dietary Services See Pages 45-47	10/17/16
	(1) Prescribed by physician assistant, of the diet as ordered (2) Planned, prequalified personnel at The current Heanual or The Manual or The Manual the American Dies shall be readily availating, and (3) All diets shall	ed for residents shall be: by the resident's physician, or APRN with a record of red kept on file; epared, and served by according to diet prescription. Hawaii Dietetic Association ual of Clinical Dietetics of etetic Association or both	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 licens and discussed the facility policy infraction, i regards to providing nutritional care and se impaired nutrition, and unplanned weight of 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 was conducted with licensed and unlicensed staff with an emphasis on documenting weights taken at the first of the month with variance documenting food/fluid consumption accurated the importance of monitoring lab values integrity and RD recommendations.	in ervices for change. on & e liquid d nursing ights es noted; ately

Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 4 154 Continued From page 48 4 154 Continued from Page 48 10/17/16 3. Corrective action/systemic changes: All licensed staff meeting was conducted, to review (4) Therapeutic or special diets shall be the facility policy for Nutrition and weight changes, planned by a dietitian and served accordingly as with emphasis on accuracy with weight taking, prescribed by the resident's physician, meal/fluid consumption and monitoring of lab physician assistant, or APRN. 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. This Statute is not met as evidenced by: Communication with DSM to RD to PCP and to Based on observations, EMR and MR reviews DON will be maintained by DSM in a Binder and staff interviews the facility failed to ensure labelled "Nutrition at Risk". that 1 of 38 sampled residents 4. Monitoring of Corrective Action to Ensure No. provided nutritional care and services for Recurrence: impaired nutrition and unplanned weight change. The DON/designee will conduct an observation of and thus, did not meet the nutrient, texture, and meetings and binder weekly, monthly and at fluid needs of this one resident. random to ensure compliance with facility protocol for impaired nutrition. The results of the Findings include: 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%.

Office of Health Care Assurance

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PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
4 154	Continued From pa	qe 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 lice and discussed the facility policy infraction regards to providing nutritional care and impaired nutrition, and unplanned weight Staff received inservice on impaired nutritively. 2. Identification of other Residents' Having the Potential of Being Affected: A review of personal preferences, food and was conducted with licensed and unlicenses staff with an emphasis on documenting with taken at the first of the month with variant documenting food/fluid consumption accurant and the importance of monitoring lab valuatintegrity and RD recommendations. 3. Corrective action/systemic changes: All licensed staff meeting was conducted the facility policy for Nutrition and weight with emphasis on accuracy with weight to meal/fluid consumption and monitoring of values, skin integrity and RD recommendations, skin integrity and RD recommendations. Compliance will be monitored by resident outcomes — weight gain — and satisfaction will represent RD in all careplan and IDT in will report any updated information to RE Communication with DSM to RD to PCP at DON will be maintained by DSM in a Bindulabelled "Nutrition at Risk". 4. Monitoring of Corrective Action to Ensure Recurrence: The DON/designee will conduct an observation meetings and binder weekly, monthly and random to ensure compliance with facility for impaired nutrition. The results of the monitoring will be reported to the quarter meeting and necessary actions will be implied as appropriate. 2nd quarter goal will be 90 3rd quarter goal will be 100%.	the the the the the the the the the the	10/17/16

Hawaii Dept. of Health, Office of Health Care Assurance

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LEGACY	/ HILO REHABILITATI	ON & NURSING C 563 KAUN HILO, HI	MANA DRIVE 96720		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
4 154	Continued From pa	ge 50	4 154	1. Corrective action for resident in sample: The DON, NHA and SDC met with the licer and discussed the facility policy infraction regards to providing nutritional care and impaired nutrition, and unplanned weight Staff received inservice on impaired nutrit weights. 2. Identification of other Residents' Having Potential of Being Affected: A review of personal preferences, food and was conducted with licensed and unlicent staff with an emphasis on documenting weight taken at the first of the month with variated documenting food/fluid consumption access and the importance of monitoring lab valuintegrity and RD recommendations. 3. Corrective action/systemic changes: All licensed staff meeting was conducted the facility policy for Nutrition and weight with emphasis on accuracy with weight meal/fluid consumption and monitoring values, skin integrity and RD recommence Compliance will be monitored by resident outcomes — weight gain — and satisfaction will report any updated information to Recommence in the facility of the RD to PCP DON will be maintained by DSM in a Binal labelled "Nutrition at Risk". 4. Monitoring of Corrective Action to Ensure Recurrence: The DON/designee will conduct an obsere meetings and binder weekly, monthly an random to ensure compliance with facility for impaired nutrition. The results of the monitoring will be reported to the quarter meeting and necessary actions will be imas appropriate. 2nd quarter goal will be 3rd quarter goal will be 100%.	the the the the the the the the the the

Hawaii Dept. of Health, Office of Health Care Assurance

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE	SURVEY LETED
		125065	B. WING		09/1	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LEGACY	HILO REHABILITATION	ON & NURSING C 563 KAUI HILO, HI	MANA DRIVE 96720	:		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	(X5) COMPLETE DATE
4 154	Continued From pa	ge 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 lice and discussed the facility policy infraction regards to providing nutritional care and impaired nutrition, and unplanned weigh Staff received inservice on impaired nutr weights. 2. Identification of other Residents' Having Potential of Being Affected: A review of personal preferences, food a was conducted with licensed and unlicenstaff with an emphasis on documenting taken at the first of the month with varia documenting food/fluid consumption accommendations. 3. Corrective action/systemic changes: All licensed staff meeting was conducted the facility policy for Nutrition and weigh with emphasis on accuracy with weight meal/fluid consumption and monitoring values, skin integrity and RD recommend Compliance will be monitored by reside outcomes – weight gain – and satisfaction will represent RD in all careplan and IDT will report any updated information to R Communication with DSM to RD to PCP DON will be maintained by DSM in a Bindabelled "Nutrition at Risk". 4. Monitoring of Corrective Action to Ensur Recurrence: The DON/designee will conduct an obser meetings and binder weekly, monthly an random to ensure compliance with facilit for impaired nutrition. The results of the monitoring will be reported to the quarter meeting and necessary actions will be im as appropriate. 2nd quarter goal will be 100%.	the the liquid sed nursing veights notes noted; curately ues, skin did to hanges, taking, of lab dations. In the liquid sed nursing veights noted; curately ues, skin did to hanges, taking, of lab dations. In the liquid liquid sed nursing stable dations. In the liquid	10/17/16

Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 4 154 Continued From page 52 4 154 4 154 11-94. 1-40(b) Dietary Services 10/17/16 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 & 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%.

Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 4 154 Continued From page 53 4 154 11-94. 1-40(b) Dietary Services 4 154 10/17/16 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%.

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

A. BUILDING:

Device of Health Care Assuranc

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

09/19/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEGACY HILO REHABILITATION & NURSING C

563 KAUMANA DRIVE

(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
4 154	Continued From page 54	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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	125065	B. WING	09/19/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEGACY HILO REHABILITATION & NURSING C

563 KAUMANA DRIVE

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4 154	Continued From page 55	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 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%.	10/17/1

Hawaii Dept. of Health, Office of Health Care Assurance

			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ETED
		125065	B. WING		09/1	9/2016
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4 154	Continued From pa	ge 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 lice and discussed the facility policy infraction regards to providing nutritional care and impaired nutrition, and unplanned weigh Staff received inservice on impaired nutriweights. 2. Identification of other Residents' Having Potential of Being Affected: A review of personal preferences, food at was conducted with licensed and unlicenstaff with an emphasis on documenting taken at the first of the month with variated documenting food/fluid consumption accand the importance of monitoring lab valintegrity and RD recommendations. 3. Corrective action/systemic changes: All licensed staff meeting was conducted the facility policy for Nutrition and weight with emphasis on accuracy with weight meal/fluid consumption and monitoring values, skin integrity and RD recommence Compliance will be monitored by resider outcomes – weight gain – and satisfaction will report any updated information to R Communication with DSM to RD to PCP DON will be maintained by DSM in a Bindabelled "Nutrition at Risk". 4. Monitoring of Corrective Action to Ensur Recurrence: The DON/designee will conduct an obser meetings and binder weekly, monthly an random to ensure compliance with facility for impaired nutrition. The results of the monitoring will be reported to the quarter meeting and necessary actions will be im as appropriate. 2nd quarter goal will be im as appropriate. 2nd quarter goal will be im as appropriate. 2nd quarter goal will be imas appropriate. 2nd quarter goal will be imas appropriate. 2nd quarter goal will be imas appropriate. 	the the diquid sed nursing veights nces noted; turately ues, skin d, to review ht changes, taking, of lab dations. ht bn. DSM meetings; D. and to der e No vation of d at y protocol erly QA plemented	10/17/16

Hawaii Dept. of Health, Office of Health Care Assurance

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED	
		125065	B. WING		09/1	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
4 154	Continued From pa	ge 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 licent and discussed the facility policy infraction, regards to providing nutritional care and se impaired nutrition, and unplanned weight Staff received inservice on impaired nutriti weights. 2. Identification of other Residents' Having the Potential of Being Affected: A review of personal preferences, food and was conducted with licensed and unlicenses staff with an emphasis on documenting wetaken at the first of the month with variant documenting food/fluid consumption accurant the importance of monitoring lab value integrity and RD recommendations. 3. Corrective action/systemic changes: All licensed staff meeting was conducted, the facility policy for Nutrition and weight with emphasis on accuracy with weight tal meal/fluid consumption and monitoring of values, skin integrity and RD recommendation will be monitored by resident outcomes — weight gain — and satisfaction. will represent RD in all careplan and IDT m will report any updated information to RD. Communication with DSM to RD to PCP an DON will be maintained by DSM in a Binde labelled "Nutrition at Risk". 4. Monitoring of Corrective Action to Ensure 1 Recurrence: The DON/designee will conduct an observar meetings and binder weekly, monthly and a random to ensure compliance with facility pro impaired nutrition. The results of the monitoring will be reported to the quarterly meeting and necessary actions will be imple as appropriate. 2nd quarter goal will be 905 3rd quarter goal will be 100%.	in ervices for change. on & liquid during ights es noted; rately es, skin to review changes, king, flab tions. DSM eetings; d to r	10/17/16

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEGACY HILO REHABILITATION & NURSING C

563 KAUMANA DRIVE HILO, HI 96720

	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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 154	Continued From page 58	4 154	4 154 11-94. 1-40(b) Dietary Services See Pages 48-58	10/17/16
P. T. T. T. T. T. T. T. T. T. T. T. T. T.				
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

					FORM	APPROVED
Hawaii I	Dept. of Health, Offic	e of Health Care Assuranc				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY	
		125065	B. WING		09/1	9/2016
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(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	CORRECTIVE ACTION SHO	OULD BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	4 159 11-941. 1-41(a) Storage and Han	ling of Food	DATE
4 159	Continued From pa	ge 59	4 159	Corrective Action for Resident in Salaria	ample:	10/17/16
	·	_		The DON and NHA met with the st	aff involved	
		ondensation, leakages,		and discussed the facility policy inf	raction in	
	rodents, or verr	nin; and		regards to the facility failing to stor	e, prepare,	
	4-1 - 1 1 1 1			distribute, and serve food under sa	nitary	
		foods shall be stored at the		conditions, failing to ensure dishes	and utensils	
		s to conserve nutritive value		are cleaned and stored under sanit and failing to ensure that staff follo	ary conditions,	
	and prevent spo	oilage.		hand sanitization and food handling	wed proper	
				the prevention of foodborne illness	es All dietany	
				staff received inservice on preventi	on of	
		met as evidenced by:		foodborne illness. A review of the	proper food	
		iew, observations, and		temperatures, proper cleansing of		
		y failed to store, prepare,		dishes/utensils, their storage and pr	oper hand	
		e food under sanitary		sanitizing; food handling by involved	staff was	
		ility also failed to ensure		also conducted with the emphasis o	n sanitary	
		are cleaned and stored under		conditions and the prevention of for	odborne	
		In addition, based on		illness. Inservice on 3 compartment sink use, sanitizing testing, covering	cleansing &	
		aff interview, the facility failed		items, food items to be labeled with	#5 1100 h	
	to ensure that staff	followed proper hand		dates".	to use by	
•		d handling practices for the		2. <u>Identification of Other Resident Hav</u>	ng the	
	prevention of foodbo	orne ilinesses.		Potential of Being Affected:	<u></u>	
	The allie was to also also			The DON /designee will monitor the	licensed staff	
	Findings include:			involved, daily, weekly, and at rando	m, to ensure	
	1) On 0/10/0016	DIGG A M. in letter an Account to		compliance with proper food temper	atures,	
		9:33 A.M. in kitchen tour with		proper cleansing, proper hand sanitize	ing and	
		anager (FSM) found the		proper storage.		
		without a label to indicate a		3. Corrective Action/Systemic Changes:		
		n date: one single serving		All licensed staff meeting was conductive the facility and it	ted to	
		closed bag of tater tots		review the facility policy and procedu storage, sanitizing, proper food temp	re on	
		recently opened; one gallon		and cleansing. Logs/binders will be d	eratures,	
		pet half full. In the cooking	•	and maintained to monitor and track	compliance	
		elf above the gas stove was a		All involved staff will be monitored to	ensure	
,		about 3/4th full of yellow		compliance with audit tools, no missi	ng entries	
		didentified as cooking oil.		and no recurrence of the infraction.		
		proper storage the FSM	•	4. Monitoring of Corrective actions to E	isure No	
}		oil should be covered and		Recurrence:		
	labeled. In the dry p	antry storage was a shelf		The DON/DSM/designee will conduct	observation	

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holding gallon sized canned foods; boxes of

cream of wheat; boxes pancake mixes; and

that these items were the date received.

boxes of cake mixes all incompletely labeled with

just month and day no year. The FSM explained

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and audits of the involved staff and

meeting and necessary actions will be

quarter.

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

implemented as appropriate. QA goals is 90% compliance 2nd quarter & 100% compliance 3rd ation sheet 60 of 95

Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED 125065 B. WING 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 4 159 Continued From page 60 4 159 11-94.1-41(a) Storage and handling of food 4 159 10/17/16 Corrective Action for Resident in Sample: 2) The facility failed to demonstrate that the The DON and NHA met with the staff involved quantenary sanitizing solution was at 150 - 400 and discussed the facility policy infraction in ppm recommended for the 3 compartment sink regards to the facility failing to store, prepare, used to wash large cooking and food prep items. distribute, and serve food under sanitary On the morning of 9/13/2016 observed FSM test conditions, failing to ensure dishes and utensils are cleaned and stored under sanitary conditions, the sanitizing agent for the sink used to soak large cooking items using a litmus paper test and failing to ensure that staff followed proper hand sanitization and food handling practices for strip. The FSM ran the sanitizing agent into a the prevention of foodborne illnesses. All dietary small tub then dipped the litmus test strip in the staff received inservice on prevention of disinfectant tub for 10 seconds and removed. foodborne illness. A review of the proper food The test strip indicated a reading of less than temperatures, proper cleansing of 100 parts per million (ppm) the FSM manager dishes/utensils, their storage and proper hand stated, "I think it's water". When asked what ppm sanitizing; food handling by involved staff was the facility followed, the FSM stated "between 200 also conducted with the emphasis on sanitary - 400 ppm. On 9/16/2016 at 8:49 A.M. observed conditions and the prevention of foodborne the 3rd compartment that held the sanitizing illness. Inservice on 3 compartment cleansing & solution overflowing out of the compartment onto sink use, sanitizing testing, covering of food the counter. The Dietary Aide (DA) #1 was asked items, food items to be labeled with "to use by dates". to test the 3rd compartment. The litmus test on Identification of Other Resident Having the the overflowing sink indicated less than 100 ppm. Potential of Being Affected: The DA drained the 3rd compartment and refilled The DON /designee will monitor the licensed staff the compartment with sanitizing solution to the involved, daily, weekly, and at random, to ensure recommended water level. The litmus test was compliance with proper food temperatures, repeated and indicated for the second time less proper cleansing, proper hand sanitizing and than 100 ppm. Observed a chart above the sink proper storage. that suggested the sanitizing reading should be Corrective Action/Systemic Changes: between 150 - 400 ppm. On 9/16/16 at 11:56 All licensed staff meeting was conducted to A.M. the FSM provided a policy for Pot-Pan review the facility policy and procedure on Washing (3 Compartment Sink), however the storage, sanitizing, proper food temperatures, and cleansing. Logs/binders will be developed policy was titled for the previous facility

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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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ion sheet 61 of 95

and maintained to monitor and track compliance.

All involved staff will be monitored to ensure compliance with audit tools, no missing entries

Monitoring of Corrective actions to Ensure No

The DON/DSM/designee will conduct observation

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

and no recurrence of the infraction.

and audits of the involved staff and

Recurrence:

Hawaii Dept. of Health, Office of Health Jare Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING _ 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE **DEFICIENCY**) 4 159 11-94.1-41(a) Storage and handling of food 4 159 4 159 Continued From page 61 10/17/16 dining room. Staff #20 proceeded to remove the Corrective Action for Resident in Sample: protective coverings off the food dishes for R #41. The DON and NHA met with the staff involved and discussed the facility policy infraction in When asked about hand sanitizing after kneeling regards to the facility failing to store, prepare, and touching her uniform clothing, Staff #20 distribute, and serve food under sanitary stated "I forgot to sanitize". conditions, failing to ensure dishes and utensils are cleaned and stored under sanitary conditions, 4) On 9/13/2016 during a noon meal observation and failing to ensure that staff followed proper in the dining room observed a serving cart with a hand sanitization and food handling practices for meal tray waiting to be served with an uncovered the prevention of foodborne illnesses. All dietary dish of sliced sugar beets. The serving cart was staff received inservice on prevention of waist level high and situated next to a sink in the foodborne illness. A review of the proper food dining room. Random staff were observed temperatures, proper cleansing of washing their hands between tray passes next to dishes/utensils, their storage and proper hand the serving cart with the uncovered sugar beet sanitizing; food handling by involved staff was also conducted with the emphasis on sanitary dish. On 9/14/2016 at 2:07 P.M. in an interview conditions and the prevention of foodborne with the Food Service Manager (FSM) on the illness. Inservice on 3 compartment cleansing & observed unwrapped dish of sugar beets in the sink use, sanitizing testing, covering of food dining room. The FSM stated the food warming items, food items to be labeled with "to use by cart delivered to the dining room holds trays for dates". both the dining room residents and residents who Identification of Other Resident Having the eat in their room, the travs are sorted in the dining Potential of Being Affected: room. Trays being served to the dining room The DON /designee will monitor the licensed staff residents have uncovered side dishes, trays involved, daily, weekly, and at random, to ensure going to the resident rooms should be covered. compliance with proper food temperatures, In the process of sorting trays the uncovered food proper cleansing, proper hand sanitizing and sits on the serving carts. The FSM proper storage. acknowledged that uncovered food is an infection Corrective Action/Systemic Changes: All licensed staff meeting was conducted to control concern. review the facility policy and procedure on storage, sanitizing, proper food temperatures, 5) On 9/16/2016 at 8:49 A.M. observed serving 10/17/16 and cleansing. Logs/binders will be developed carts with trays holding plates and cups of and maintained to monitor and track compliance. partially eaten foods and liquids. The Dietary All involved staff will be monitored to ensure Aide #1 shared that these trays were collected compliance with audit tools, no missing entries from the residents completed morning meal and and no recurrence of the infraction. needed to be scrapped and cleaned. The serving Monitoring of Corrective actions to Ensure No cart sat next to a metal shelf. Hanging on the Recurrence: side of the metal shelf were pots and pans. The DON/DSM/designee will conduct observation When asked the DA #1 confirmed that the pots and audits of the involved staff and and pans on the shelf were clean. Observed no binders/logs/documents daily, weekly, monthly and at random to ensure compliance with the barrier between the clean shelf and serving cart

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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

Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 4 159 Continued From page 62 4 159 11-94.1-41(a) Storage and handling of food 4 159 10/17/16 holding dirty plates and cups. When asked if the Corrective Action for Resident in Sample: cart can be bumped causing food and liquid to The DON and NHA met with the staff involved splash onto the clean pots and pans the DA #1 and discussed the facility policy infraction in regards to the facility failing to store, prepare, stated the area is very narrow, gets crowded, distribute, and serve food under sanitary splashing could occur. Later that day the FSM conditions, failing to ensure dishes and utensils acknowledge that keeping the used meal travs on are cleaned and stored under sanitary conditions. serving carts next to the clean shelf is a potential and failing to ensure that staff followed proper for the contamination. hand sanitization and food handling practices for the prevention of foodborne illnesses. All dietary 6) During the dining observation on 09/13/2016 staff received inservice on prevention of 10/17/16 at 12:13 P.M. on the skilled nursing unit, it was foodborne illness. A review of the proper food found the residents' meal travs had uncovered temperatures, proper cleansing of foods such as the bowl of beets, bowl of fruit dishes/utensils, their storage and proper hand cocktail mix and orange juice, which were being sanitizing; food handling by involved staff was delivered by the certified nurse aides on the unit. also conducted with the emphasis on sanitary As these side dishes were not covered, there conditions and the prevention of foodborne exists the potential for contamination of the food illness. Inservice on 3 compartment cleansing & sink use, sanitizing testing, covering of food and drink before reaching the intended residents. items, food items to be labeled with "to use by such that the staff or an individual passing by dates". during the tray delivery in the hallways Identification of Other Resident Having the inadvertenly coughed or sneezed. 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. 10/17/16 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. Monitoring of Corrective actions to Ensure No Recurrence: The DON/DSM/designee will conduct observation and audits of the involved staff and 10/17/16 binders/logs/documents daily, weekly, monthly

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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

FORM APPROVED Hawaii Dept. of Health, Office of Health Jare Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) 4 159 Continued From page 63 4 159 4 159 11-94.1-41(a) Storage and handling of food 10/17/16 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 10/17/16 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 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. 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. Monitoring of Corrective actions to Ensure No Recurrence: The DON/DSM/designee will conduct observation and audits of the involved staff and

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Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED				
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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) COMPLETI DATE
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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Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING _ 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

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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				
int ea ob me ne as co Fir 1. on as co Fu Pe fac NH Ce for	terdisciplinary comprehensive care plan for ach resident that includes measurable ojectives and timetables to meet a resident's edical, nursing, and mental and psychosocial eds that are identified in the comprehensive sessment for 4 of 38 residents whose omprehensive care plans were reviewed. The policy and procedure provided by the NHA in 9/16/16 titled, "Care Planning for Residents" is Policy No. 40, is the previous management ompany's policy with no origination date. For author, in the body of this policy, it states under colicy: (Other company's name) and its affiliated cilities". As such, this policy produced by the HA to be Legacy Hilo Rehabilitation & Nursing enter's policy and procedure on care planning in residents is not their policy, and no other bolicy 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				

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Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG 4 174 11-94.1-43(b) Interdisciplinary care process Corrective Action for Resident in Sample: 4 174 4 174 Continued From page 66 10/17/16 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 10/17/16 careplanning. 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. Corrective and Systemic Changes: All licensed staff meeting as conducted, to review the facility policy and procedure for comprehensive assessments, careplans, 10/17/16 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. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee, NHA/designee and Pharmacy consultant will conduct a careplan

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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

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4 174	Continued From pa	age 67	4 174	1. Corrective Action for Resident in The DON, NHA and SDC met with involved and discussed the facility infraction, in regards to comprehe assessments, development of concareplans, cross reference to unnumerical drugs and their right to participate careplanning with an emphasis or coding, collaboration with Rehabit GG, review of medication regimen residents' right to participate with careplanning. 2. Identification of Other Resident H Potential of Being Affected: The DON/designee will monitor the staff weekly and at random to ensicompliance with proper coding of limitations in ROM, that Medication appropriate for usage with PRNs' documented as well as behavioral completed; all residents will have completed; all residents will have competed as the proper coding of the discount of the proper coding of the discount of the proper coding of	the staff / policy ensive hprehensive ecessary e in accuracy in for Section s, and the e involved ure functional ns are logs hareplan eir pdated to els	0/17/10
			·	3. Corrective and Systemic Changes: All licensed staff meeting as conductive review the facility policy and proce comprehensive assessments, carepunnecessary medication and particular with Careplanning. The emphasis is accurate assessments, individualize careplans, discontinuance of unnecemedications, participation with care and attendance at meetings. The MRAI will drive the process. 4. Monitoring of Corrective Actions to No Recurrence: The DON/designee, NHA/designee and Pharmacy consultant will conduct a administrative overview weekly, mo	dure for lans, pation son dessary eplanning IDS and Ensure 10/17 and careplan	7/16

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Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG 4 174 11-94.1-43(b) Interdisciplinary care process Corrective Action for Resident in Sample: 4 174 Continued From page 68 4 174 The DON, NHA and SDC met with the staff 10/17/16 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. 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. 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 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 Office of Health Care Assurance compliance with facility's administrative guidelines for assessment, careplanning and STATE FORM 6899 ion sheet 69 of 95

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

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	LE CONSTRUCTION	(X3) DATI	SURVEY
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,		125065	B. WING		09/	19/2016
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'4 174	Continued From pa	ge 69	4 174	1. Corrective Action for Re The DON, NHA and SDC involved and discussed to infraction, in regards to assessments, developmed careplans, cross reference drugs and their right to perform the coding, collaboration with GG, review of medication residents' right to particic careplanning. 2. Identification of Other Repotential of Being Affect The DON/designee will not staff weekly and at randocompliance with proper of limitations in ROM, that is appropriate for usage with documented as well as becompleted; all residents are meetings scheduled upor Individualized plan of careflect measurable and redesigned to achieve the head of the complete of the control of the complete of the com	met with the staff he facility policy comprehensive ent of comprehensive ent of comprehensive ent of comprehensive ent of comprehensive ent of comprehensive ent of comprehensive ent of comprehensive ent of comprehensive ent of comprehensive ent of comprehensive entition and the pate with esident Having the ed: conitor the involved ent to ensure coding of functional Medications are th PRNs' ehavioral logs will have carepian e which their e will be updated to ealistic goals	10/17/16
				aesigned to achieve the relevel of function. 3. Corrective and Systemic (All licensed staff meeting review the facility policy acomprehensive assessme unnecessary medication awith Careplanning. The eaccurate assessments, indicareplans, discontinuance medications, participation and attendance at meeting RAI will drive the process. 4. Monitoring of Corrective Monecurrence: The DON/designee, NHA/Pharmacy consultant will administrative overview will	changes: as conducted, to and procedure for ints, careplans, and participation imphasis is on dividualized of unnecessary in with careplanning igs. The MDS and Actions to Ensure designee and conduct a careplan	10/17/16

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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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX COMPLETE 4174 11-94.1-43(b) Interdisciplinary care process REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE Corrective Action for Resident in Sample: 4 174 Continued From page 70 4 174 The DON, NHA and SDC met with the staff 10/17/16 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. 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. 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 10/17/16 medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. 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 Office of Health Care Assurance guidelines for assessment, careplanning and STATE FORM 6899 the medication administration protocol;

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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

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Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED		
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4 174	Continued From pa	ge 71	4 174	<u>4 174</u> 11-94.1-43(b) Interdisciplinary care p See Pages 65-71	process	10/17/16
4 175	(c) The overall plar periodically by the indetermine if goals changes are require and as necessitate condition. This Statute is not a Based on observation interviews and facilifialed to ensure that care plans are period by a team of qualifier residents in the residents in the residents in the residents in the policy and pon 9/16/16 titled, "Cas Policy No. 40, is company's policy wire Further, in the body "Policy: (Other compacilities". As such NHA to be Legacy Honter's policy and	ty policy review, the facility residents' comprehensive dically reviewed and revised of persons for 7 of the 38	4 175	11-94.1-43(c) Interdisciplinary care p Corrective Action for Resident in Sam The DON, NHA and SDC met with the involved and discussed the facility pol infraction, in regards to comprehensive assessments, development of comprehensive assessments, development of comprehensive assessments, development of comprehensive and their right to participate in careplanning with an emphasis on according, collaboration with Rehab for Section of GG, review of medication regimens, a residents' right to participate with careplanning. Identification of Other Resident Having Potential of Being Affected: The DON/designee will monitor the instaff weekly and at random to ensure compliance with proper coding of fundimitations in ROM, that Medications appropriate for usage with PRNs' documented as well as behavioral log completed; all residents will have care meetings scheduled upon which their Individualized plan of care will be upd reflect measurable and realistic goals designed to achieve the highest pract level of function.	ple: staff licy ve chensive ssary curacy in Section and the explored ctional are eplan	10/17/16

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		125065	B. WING		09/19/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY	STATE, ZIP CODE		
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4 175	Continued From page	ge 72	4 175			_
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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 2^{nd} quarter goal is 90% and the 3rd quarter goal is

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Hawaii	Dept. of Health, Offic	e of Health Jare Assuranc				FORM	APPROVE
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					careplanning with an emphasis on a	ccuracy in	
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j					meetings scheduled upon which their		
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				"	Corrective and Systemic Changes: All licensed staff meeting as conducte	d 4-	
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					compliance with facility's administrative	.	
					guidelines for assessment, careplanning	and	
#					the medication administration protocol	;	
	Care Assurance			•	completion of appropriate behavioral lo	es ====	
TATE FORM			6899 P	•	and documentation of the effectiveness	_	sheet 74 of 95

FORM APPROVED Hawaii Dept. of Health, Office of Health, are Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE 4 175 11-94.1-43(c) Interdisciplinary care process Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff 4 175 Continued From page 74 4 175 10/17/16 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. 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. 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. Monitoring of Corrective Actions to Ensure

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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

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Hawaii	Dept. of Health, Offic	ce of Health Jare Assuranc			FORM	APPROVE
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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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG 4 175 11-94.1-43(c) Interdisciplinary care process DATE Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff 4 175 Continued From page 76 4 175 10/17/16 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 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. 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. 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 Office of Health Care Assurance and documentation of the effectiveness of STATE FORM 6899 PHI PRN and scheduled medications. The results tion sheet 77 of 95

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

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Hawaii Dept. of Health, Office of Health Jare Assurance

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Hawaii Dept. of Health, Office of Health __re Assurance

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DAŢE TAG 4 175 11-94.1-43(c) Interdisciplinary care process Corrective Action for Resident in Sample: 10/17/16 4 175 Continued From page 78 4 175 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. 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. 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. 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; Office of Health Care Assurance completion of appropriate behavioral logs STATE FORM 6899 PHL and documentation of the effectiveness of ation sheet 79 of 95

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

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Hawaii Dept. of Health, Office of Health Care Assurance

Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ 125065 B. WING 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE** LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE 4 175 11-94.1-43(c) Interdisciplinary care process Corrective Action for Resident in Sample: The DON, NHA and SDC met with the staff 4 175 Continued From page 79 4 175 10/17/16 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. 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. 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 10/17/16 medications, participation with careplanning and attendance at meetings. The MDS and RAI will drive the process. 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 Office of Health Care Assurance

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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

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	arrangement with provide consultation for ordering, stori and recordkeeping o provisions for emer This Statute is not maked on record revimembers, the facility	Il employ a licensed have a written contractual a licensed pharmacist, to on methods and procedures ng, administering, disposing, f drugs and biologicals, and gency service. The as evidenced by: The area of the service of the ser	4 184	4 184 11-94.1-46(a) Pharmaceutical 1. Corrective action for resident in The DON, NHA and SDC met with licensed staff involved and discursacility policy Infraction in regard ensuring that resident are not us unnecessary drugs; and resident use antipsychotic drugs receive goes reductions, and behavioral interventions, in an effort to is concerned these drugs. A review of each resident recommendations to PCPs as independent of the discontinuance of unnecessary medications and/or gradual dose reductions. 2. Identification of Other Residents the Potential of Being Affected: The DON/designee will receive of daily at stand up to increase away of the drugs being ordered and the potential for unnecessary medications of the drugs being ordered and the potential for unnecessary medications the DON/designee will monitor to Licensed staff involved daily, weether the drugs being ordered and the DON/designee will monitor to Licensed staff involved daily, weether the daily weether th	sample: h the ssed the ssed the ds to sing s who do gradual ontinue sidents' by DON ive with dicated ry e Having orders areness the ation. the	10/17/16

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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.

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONS	TRUCTION	(X3) DAT	E SURVEY
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					facility policy Infraction in regards t		
					ensuring that resident are not using		
					unnecessary drugs; and residents w	_	
					use antipsychotic drugs receive gra		
					dose reductions, and behavioral		
					interventions, in an effort to is cont	inue	
					these drugs. A review of each resid		
					drug regimen will be conducted by		
					and pharmaceutical representative		
					recommendations to PCPs as indica	ted	
					for discontinuance of unnecessary		
					medications and/or gradual dose reductions.		
				2			
				_	the Potential of Being Affected:	VILIE	
ĺ	•				The DON/designee will receive orde	re	
					daily at stand up to increase awarer		
					of the drugs being ordered and the	1033	
					potential for unnecessary medication	n.	
					The DON/designee will monitor the		
1					Licensed staff involved daily, weekly	, at	
					random, to ensure communication v		
					PCP thru use of a binder keeping co		
					of faxes/encounters/communication		
					with PCP; duplicated in nursing note		
					nevertheless available to PCP upon v		
					to unit. Careplan revisions will then	be	
					made as appropriate.		
					Continued from Page 81		
				3.			
					All licensed staff meeting was condu	cted	
					to review the facility policy in regard		
					ensuring residents are not receiving		
ŀ					unnecessary medications, gradual do		
1					reductions occur where indicated an		
					behavioral interventions are appropr	iate	
.				_	and careplanned.		
				4.			
					Ensure No Recurrence:		1
					The DON/designee and Pharmacy		
ffice of Heal	th Care Assurance				Consultant will conduct reviews of the		<u></u>
TATE FORM	1		6899 P	HLE	resident orders and medication regin weekly, monthly and at random to		on sheet 82 of 95
					ensure that all licensed staff is aware		511661 02 01 35
						OI.	

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 3^{rd} quarter.

Hawaii Dept. of Health, Office of Health Care Assurance

Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED 125065 B. WING 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX FACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE 4 184 11-94.1-46(a) Pharmaceutical services Corrective action for resident in sample: 4 184 Continued From page 82 4 184 10/17/16 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. 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. 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. 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 Office of Health Care Assurance facility policy regarding GDR and

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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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unnecessary medications. The results of uation sheet 83 of 95

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION 4 184 11-94.1-46(a) Pharmaceu	N SHOULD RF	(X5) COMPLETE DATE	
4 184	Continued From pa	ae 83	4 184	1. Corrective action for reside The DON, NHA and SDC me licensed staff involved and facility policy Infraction in resuring that resident are runnecessary drugs; and resuse antipsychotic drugs recommendations, in an effort these drugs. A review of early regimen will be conducted and pharmaceutical represe recommendations to PCPs for discontinuance of unnemalications and/or graduate reductions. 2. Identification of Other Restore The DON/designee will recommended and pharmaceutical represe recommendations of the drugs being ordered appropriate of the drugs being ordered potential for unnecessary The DON/designee will medicate a being and the potential for unnecessary The DON/designee will medicate a being ordered potential for unnecessary The DON/designee will medicate a being ordered potential for unnecessary with PCP; duplicated in nunevertheless available to form the potential for unnecessary with PCP; duplicated in nunevertheless available to form the potential for the facility policiensuring residents are not unnecessary medications, reductions occur where in behavioral interventions and careplanned. 4. Monitoring of Corrective Ensure No Recurrence: The DON/designee and Pl Consultant will conduct resident orders and medicated weekly, monthly and at resident orders and medicated weekly, monthly and at resident orders and medicated weekly, monthly and at resident orders and medicated weekly, monthly and at resident orders and medicated weekly, monthly and at resident orders and medicated weekly, monthly and at resident orders and medicated weekly, monthly and at resident orders and medicated weekly, monthly and at resident orders.	nt in sample: It with the discussed the egards to not using didents who do reive gradual vioral to is continue to residents' ucted by DON entative with as indicated ressary al dose didents Having cted: reive orders se awareness I and the medication. onitor the ly, weekly, at unication with eeping copies munication ursing notes PCP upon visit s will then be dic Change: was conducted y in regards to t receiving a gradual dose adicated and are appropriate Actions to harmacy eviews of the cation regimen andom to	10/17/16	
Office of Heal	Ith Care Assurance		6899	PHLB1 ensure that all licensed st facility policy regarding G unnecessary medications	DP and	on sheet 84 of 95	

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.

Hawaii Dept. of Health, Office of Health are Assurance

PRINTED: 10/10/2016 FORM APPROVED Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 563 KAUMANA DRIVE **LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 4 184 Continued From page 84 4 184 4 184 11-94.1-46(a) Pharmaceutical services 10/17/16 See Pages 81-85 4 192 11-94.1-46(i) Pharmaceutical services 10/17/16 4 192 4 192 11-94.1-46(i) Pharmaceutical services

Office of Health Care Assurance

by a

(i) Appropriately licensed and trained staff shall

administration, which entails removing an

pharmacist or manufacturer (unit dose

individual dose from a container properly labeled

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.

be responsible for the entire act of medication

included), verifying the dosage with the

Corrective Action for Resident in Sample: Inservice staff with Rx administration with

signatures acknowledging understanding.

Potential of Being Affected:

efficacy.

Identification of other Residents Having the

Unit nurse will offer PRN sleep medication.

sleep medication administered includes

Unit nurse will ensure that documentation of

16 ED

Hawaii	Dept. of Health, Offic	e of Heal are Assuranc			PRINTED FORM): 10/10/20 I APPROVE	
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
4 192	physician, or oth licensed profession responsibility pursus subchapter 15, may This Statute is not a Based on a complain	er individual to whom the all has delegated the ant to chapter 16-89, administer medications. met as evidenced by: int, record review and ty failed to provide services to attain the highest	4 192	Continued from Page 85 3. Corrective Action/Systemic Ch If PRN Rx isn't given for a perio unit nurse will notify PCP to de order should be stopped. All r records of medication adminis reviewed to ensure no missing Behavior logs, sleep logs, mood will be audited as well to ensure entries. 4. Monitoring of Corrective Action No Recurrence: Audits will be don daily by RCM DON/designees to ensure as in Monitor results will be reporte meeting & necessary actions w implemented as appropriate. (90% 2nd quarter & 100% for 3nd	od of 30 days, extermine if esident tration will be entries. d indicators re no missing ns to Ensure 1, SDC, dicated. d to the QA ill be Goal will be	10/17/16	

Office of Health Care Assurance STATE FORM

PHINTED: 10/10/2016 FORM APPROVED Hawaii Dept. of Health, Office of Health re Assuranc (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: __ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 4 192 4 192 Continued From page 86 10/17/16 4 192 11-94.1-46(i) Pharmaceutical services Corrective Action for Resident in Sample: Inservice staff with Rx administration with signatures acknowledging understanding. 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. 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 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.

Office of Health Care Assurance

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	Hawaii [Dept. of Health, Offic	e of Health Jare Assuranc	PRINTED: 10 FORM AP						
		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
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	4 192	Continued From pa	ge 87	4 192	4 192 Unnecessary drugs/Comprehensive car See Page 86, 87	replans	10/17/16			
	ė									

4 203

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

Office of Health Care Assurance

10/17/16

4203 11-94.1-53(a) Infection Control

See Pages 89-93

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STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY
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,,,,			TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE DATE
4.000	A				
4 203	Continued From pa	ge 88	4 203	4 203 11-94.1-53(a) Infection Control	10/17/16
	infection control dat	a. The DON was already		1 Correction Action 6 - Part I at a	
	informed of the lack	of hand hygiene during		Corrective Action for Resident in San The DON and SDC met inserviced the	iple:
	dining and stated th	at the staff should sanitize the	l	licensed staff involved and discussed	
	residents hands bef	ore dining and CNAs should	ĺ	facility policy infraction, in regards to	
	sanitize hands betw	een residents.		infection control with an emphasis of	
				investigation, control, prevention, of	
				infections in the facility; a record of	
				incidents and corrective actions relat	
				infections; and a requirement that st	aff
				follow handwashing guidelines as ind	icated
				by accepted professional practice. 2. Identification of Other Resident Havin	
				 Identification of Other Resident Having Potential of Being Affected: 	ig the
				The DON/designee will monitor the li	consed
ĺ				staff involved daily, weekly, and at ran	dom
]				to ensure compliance of proper	dom
Ì			:	investigation, control, prevention of	
				infections in the facility; documentation	on of
				the incidents and corrective actions re	
				to infections and proper handwashing staff.	; by all
				Corrective Action./Systemic Changes:	
				All licensed staff meeting was conduct	ed to
				review the facility policy and procedur	re on
				infection control, documentation, and	
				handwashing with the emphasis on	
				investigation, prevention and correction	
İ	Queried DON on wh	ether the facility developed		actions related to infections. All licens	
	infection control police	cies and procedures (P&P).		staff will be monitored through the use audits/tools/binders tracking infection	
	The DON stated that	t the facility was following		control practices, competency and skil	
	standard infection co	ontrol practices and if notices		ensure compliance with facility policy	
1	infection trend or clu	ster would investigate further		procedure, to ensure no recurrence of	
	and perform root cau	use analysis and provide staff		infraction. Inservice education will be	
	education. She furth	er stated that, DON since		ongoing.	
	June 2016 and on a	"learning curve," and working		 Monitoring of Corrective Actions to En 	ure
	with Staff #17 to build	d upon the existing infection		No Recurrence:	
	control program. "If	the existing infection control		The DON/designee will conduct review	s and
	program is working ti	hen wouldn't need to change		observations of licensed staff, audit	
	it." When asked wha	at were the immediate plans		tools/binders and logs weekly, monthly	

that her immediate plans were to work with the Office of Health Care Assurance

for the infection control program, the DON replied

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uation sheet 89 of 95

quarter.

at random to ensure that every licensed

guidelines. The results of the monitoring

implemented as appropriate. Goal will be 90% for the 2^{nd} Quarter & 100% for the 3^{rd}

staff is in compliance with the facility's

will be reported to the quarterly QA

meeting and necessary actions will be

FORM APPROVED

PRINTED: 10/10/2016 Hawaii Dept. of Health, Office of Health are Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 125065 09/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **563 KAUMANA DRIVE LEGACY HILO REHABILITATION & NURSING C** HILO, HI 96720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) 4 203 Continued From page 89 4 203 4 203 11-94.1-53(a) Infection Control 10/17/16 CNAs and nurses on hand hygiene, peri-care. Corrective Action for Resident in Sample: and MD notification of infections. The DON and SDC met inserviced the licensed staff involved and discussed the Queried if the the DON was going to use Center facility policy infraction, in regards to for Disease Control (CDC) and/or World Health infection control with an emphasis on Organization (WHO) as a resource to further investigation, control, prevention, of develop infection control P&Ps and she stated infections in the facility; a record of that will probably use WHO since noticing more incidents and corrective actions related to "international" residents. The DON stated that infections; and a requirement that staff follow handwashing guidelines as indicated she was working with nurses on the unit to by accepted professional practice. determine integrity of current infection control Identification of Other Resident Having the program and outcomes. "If there are things that I Potential of Being Affected: can do to enhance the infection control program The DON/designee will monitor the licensed and whether outcomes are beneficial to the staff involved daily, weekly, and at random resident(s). "When asked to clarify statement the to ensure compliance of proper DON stated, "If it's more UTIs or more investigation, control, prevention of Respiratory, than that's the pathway I will take. infections in the facility; documentation of Also looking at the individual's propensity toward the incidents and corrective actions related infections." to infections and proper handwashing by all The DON further stated, "My hope as the DON is Corrective Action./Systemic Changes: All licensed staff meeting was conducted to to work with the unit that they are able to review the facility policy and procedure on collaborate and identify prevailing factors for infection control, documentation, and potential infections and implement whatever is handwashing with the emphasis on appropriate, (e.g. if Cipro doesn't work would investigation, prevention and corrective know that cannot use that antibiotic; If lab values actions related to infections. All licensed don't change, need to collaborate with the doctor staff will be monitored through the use of if not resolved.)" audits/tools/binders tracking infection control practices, competency and skills to

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condition is.

Queried how the DON was alerted of infections

"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

Queried the DON on how the facility used records

of incidents to improve it's infection control

processes and outcomes by taking corrective

to check-in if antibiotics working, etc./whatever

on the units and she stated that at daily

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ensure compliance with facility policy and

procedure, to ensure no recurrence of the

Monitoring of Corrective Actions to Ensure

The DON/designee will conduct reviews and

infraction. Inservice education will be

observations of licensed staff, audit tools/binders and logs weekly, monthly, and

at random to ensure that every licensed

guidelines. The results of the monitoring

implemented as appropriate. Goal will be 90% for the 2nd Quarter & 100% for the 3rd

staff is in compliance with the facility's

will be reported to the quarterly QA

meeting and necessary actions will be

ongoing.

quarter.

No Recurrence:

ation sheet 90 of 95

Hawaii [Dept. of Health, Offic	e of Health Jare Assuranc				V
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY	,
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4 203	Continued From pa	ge 90	4 203	4 203 11-94.1-53(a) Infection Control	10/17,	/16
	accuracy of data be incidents to improve just 3 months on the program with new 0 new staff, etc. The facility failed to control program has prevention and control data collection, sur	ated that needs to look at sing collected and looking at e processes and outcomes but e job and trying to set-up cMs (Case Managers) and demonstrate that the infection components of an infection trol program which includes reillance, planning, organizing, monitoring and maintaining all the program.		 Corrective Action for Resident in Sal The DON and SDC met inserviced the licensed staff involved and discussed facility policy infraction, in regards to infection control with an emphasis of investigation, control, prevention, or infections in the facility; a record of incidents and corrective actions related infections; and a requirement that stoed follow handwashing guidelines as incompact by accepted professional practice. Identification of Other Resident Having Potential of Being Affected: The DON/designee will monitor the list staff involved daily, weekly, and at rare to ensure compliance of proper investigation, control, prevention of infections in the facility; documentation the incidents and corrective actions reto infections and proper handwashing staff. Corrective Action./Systemic Changes: All licensed staff meeting was conduct review the facility policy and procedur infection control, documentation, and handwashing with the emphasis on investigation, prevention and corrective actions related to infections. All licenses staff will be monitored through the use audits/tools/binders tracking infection control practices, competency and skill ensure compliance with facility policy a procedure, to ensure no recurrence of infraction. Inservice education will be ongoing. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee will conduct reviews observations of licensed staff, audit tools/binders and logs weekly, monthly, 	ted to aff dicated and the consect and the con	′16

Office of Health Care Assurance

STATE FORM

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quarter.

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 2^{nd} Quarter & 100% for the 3^{rd}

ation sheet 91 of 95

Hawaii Dept. of Health, Office of Health Jure Assurance

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		EG9 VALU	MANA DRIV				
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244	CUMMADV CTA		1	T			
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	•	,	,,,,		DEFICIENCY)	11031	
4.000	0 " 15			 	202 44 04 4 52/ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
4 203	Continued From pa	ge 91	4 203	4	203 11-94.1-53(a) Infection Control		10/17/16
				1.	Corrective Action for Decident in Sec		
				1 .			
					The DON and SDC met inserviced th	-	
					licensed staff involved and discussed		
					facility policy infraction, in regards to		
					infection control with an emphasis o		
			1		investigation, control, prevention, of	f	
					infections in the facility; a record of		
· ·			1		incidents and corrective actions relat		
1			1		infections; and a requirement that st		
			1	İ	follow handwashing guidelines as inc	licated	
ļ					by accepted professional practice.		
				2.		ng the	
					Potential of Being Affected:		10/17/16
					The DON/designee will monitor the I		-0,17,10
				1	staff involved daily, weekly, and at ra	ndom	
					to ensure compliance of proper		
7					investigation, control, prevention of		
					infections in the facility; documentat	ion of	
					the incidents and corrective actions r	elated	
					to infections and proper handwashin	g by all	
					staff.		
				3.	Corrective Action./Systemic Changes	<u>:</u>	
İ					All licensed staff meeting was conduc	ted to	
1					review the facility policy and procedu	ire on	
			1		infection control, documentation, and	d	
					handwashing with the emphasis on		
			1		investigation, prevention and correct	ive	
			1		actions related to infections. All licen	sed	
					staff will be monitored through the u	se of	
					audits/tools/binders tracking infectio	n	
					control practices, competency and sk		
				1	ensure compliance with facility policy		
					procedure, to ensure no recurrence o	f the	
]	infraction. Inservice education will be	- 1	
					ongoing.		
				4.	Monitoring of Corrective Actions to E	nsure	
					No Recurrence:		
					The DON/designee will conduct review	ws and	
					observations of licensed staff, audit		
ļ					tools/binders and logs weekly, month	lv. and	
					at random to ensure that every license		

Office of Health Care Assurance

STATE FORM

6899

PHL

quarter.

staff is in compliance with the facility's guidelines. The results of the monitoring

implemented as appropriate. Goal will be 90% for the 2^{nd} Quarter & 100% for the 3^{rd}

will be reported to the quarterly QA meeting and necessary actions will be

ition sheet 92 of 95

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Hawaii	Dept. of Health, Offi	ice of Health Care Assuranc			FOR	MAPPROVE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTI	PLE CONSTRUCTION		
ANU PLAI	AN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			E SURVEY
		1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4-		FLETE
	<u></u>	125065	B. WING			
NAME OF	F PROVIDER OR SUPPLIER				09/	/19/2016
1		OTTLETA		, STATE, ZIP CODE		
	Y HILO REHABILITATION	HILO, HI	UMANA DRIVI I 96720	E		
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	101	T
TAG	REGULATORY OR LS	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	II D RE	COMPLETE DATE
4 203	Continued From page	ige 92	4 203	4 203 11-94.1-53(a) Infection Control		10/17/16
F				1. Corrective Action for Resident in Sar The DON and SDC met inserviced the licensed staff involved and discussed facility policy infraction, in regards to infection control with an emphasis of investigation, control, prevention, of infections in the facility; a record of incidents and corrective actions related infections; and a requirement that staff follow handwashing guidelines as independent by accepted professional practice. 2. Identification of Other Resident Having Potential of Being Affected: The DON/designee will monitor the licensure compliance of proper investigation, control, prevention of infections in the facility; documentation the incidents and corrective actions related infections and proper handwashing staff. 3. Corrective Action./Systemic Changes: All licensed staff meeting was conducted review the facility policy and procedure infections control.	the ed the ed to on of elated on of elated ed the elated ed to other elated ed to other elated ed to elated ed to elated ed to elated ed to elated ed to elated ed to elated ed to elated ed to elated ed to elated ed to elated ed to elated elated ed to e	
				infection control, documentation, and handwashing with the emphasis on investigation, prevention and corrective actions related to infections. All license staff will be monitored through the use audits/tools/binders tracking infection control practices, competency and skills ensure compliance with facility policy an procedure, to ensure no recurrence of thinfraction. Inservice education will be ongoing. 4. Monitoring of Corrective Actions to Ensure No Recurrence: The DON/designee will conduct reviews a observations of licensed staff, audit tools/binders and logs weekly, monthly, a at random to ensure that every licensed	ve ed e of s to ind the ure and	

Office of Health Care Assurance STATE FORM

6899 PHL 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

quarter.

implemented as appropriate. Goal will be 90% for the 2nd Quarter & 100% for the 3rd uation sheet 93 of 95

Hawa	ii Dept. of Health, Offic	ce of Health Care Assurance			FOR	M APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
125065		B. WING		09	09/19/2016	
NAMEC	F PROVIDER OR SUPPLIER	STREET	DDRESS, CITY	, STATE, ZIP CODE		
LEGA	CY HILO REHABILITATI	ON & NURSING C 563 KAU HILO, H	JMANA DRI\ I 96720	/E		
(X4) ID PREFI) TAG	THE PROVIDER OR SUPPLIER THILO REHABILITATION & NURSING C SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 93 The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by:		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE	
4 20	Continued From pa	ge 93	4 203	4 203 11-94.1-53(a) Infection Cont See Pages 89-93	rol	10/17/16
4 243	(a) The facility shall maintain all essential mechanical, electrical, and resident care		4 243	F456 483.70(c)(2) ESSENTIAL EQUIPMENT SAFE OPERATING CONDITION See Page 95	ENT,	10/17/16
	Based on observation interview, the facility f	n, record review and staff failed to maintain all full electrical, and patient care				
	essential mechanical equipment in safe op-	ailed to maintain all				

STATEME	NT OF DEFICIENCIES	ce of Health Care Assuranc			No parent	FUR	M APPROV	
AND PLAN	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DAT	(X3) DATE SURVEY COMPLETED	
		125065	B. WING _	•		00	110/001	
NAME OF PROVIDER OR SUPPLIER STREET			DDRESS, CIT	/ QTATE 7	ID CODE	1 09	/19/2016	
LEGACY	HILO REHABILITATI		JMANA DRI		IP CODE			
		HILO, HI		-			*	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECT	ION		
TAG 4 243	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	CR	EACH CORRECTIVE ACTION SHOU OSS-REFERENCED TO THE APPRO DEFICIENCY)	I D BE	COMPLET DATE	
T e fo	observed there were certain therapy mac by the residents. The restorator, the Scifit Omnicycle. The Rewhere the inspection machines, and she shand new. However found on these mach or tracking logs produmaintenance date are the vendor/manufact. During an interview of Staffing Coordinator she stated she made equipment and order given it to the previous she said she ordered and the maintenance comewhere.	facility's rehabilitation 15/2016 at 3:33 P.M., it was a no inspection stickers on hines/equipment being used nese consisted of the Scifit recumbent bike and the hab Director was queried n stickers were on the stated the equipment was ar, no inspection stickers were nines, nor were any service uced as to the last service or nd/or future service dates by urer. with the Central Supply and on 09/15/2016 at 3:49 P.M., an inventory of all the ed the stickers, but had as maintenance director. I these inspection stickers tags and had the invoices	1	2. 1. So record in the cord in	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 sticker service or tracking logs was also conducted with the emphasis on maintaining these logs to indicate the last service or maintenance date and for future service dates by the vendor/manufacturer. Identification of Other Resident Having the Potential of Being Affected: The DON/designee will monitor the taff involved, daily, weekly, and at andom to ensure compliance of propenspection stickers, service/tracking togs and that the last service date is seted by vendor. Orrective Action/Systemic Changes: Il licensed staff meeting was conducted to review the facility policy and procedure for maintaining all essential mechanical, electrical, and estient care equipment. All equipment therapy suite has been calibrated and beled with the calibration date. The ems included are Scifit Restorator—22/2016; Scifit Recumbent	nt s, e	10/17/16	
				M 9/ 4. <u>M</u> <u>En</u> Th	22/2016; Omnicycle 5/2016; Hi/Lo at Table 9/22/2016; Hydrocollator 22/2016; Parrafin Bath 9/22/2016. Onitoring of Corrective Actions to sure No Recurrence: e DON/designee will conduct			
	•			ob:	servations weekly, monthly and at			
of la = 121; 2	<u> </u>				dom to ensure that all essential chanical, electrical and patient care			
of Health (FORM	Care Assurance			equ	ipment is in safe operating			
		689	99 PI	ILI cor	dition, properly inspected, and cked with service dates to be in	nuation	sheet 95 of 95	

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.