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	125048	A. BUILDING: _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN PEARL NURSING FACILITY	45-181 WAIKALUA ROAD KANEOHE, HI 96744

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4 000	11-94.1 Initial Comments A re-licensure survey was conducted by the Hawaii State Survey Agency, SA, from February 16 to 19, 2016. The census upon entrance was 96 residents.	4 000	RECEIVED 2016 MAR 22 P 4:00 STATE OF HAWAII MEDICARE	
4 088	11-94.1-16(a) Governing body and management (a) Each facility shall have an organized governing body, or designated persons functioning as the governing body, that has overall responsibility for the conduct of all activities. The facility shall maintain methods of administrative management that assure that the requirements of this section are met. This Statute is not met as evidenced by: Based on observations and staff interviews, the facility did not develop and implement plans of action to correct identified quality deficiencies. Findings include: An interview with the outgoing Administrator, incoming Administrator, Director of Operations, DON, and NOS regarding the Quality Assessment and Assurance (QAA) committee's plans to correct identified quality deficiencies. The facility had several projects they were working on based on their own internal mock QIS survey. These projects included infection control, environment, and psychotropic medication use. However, they were not doing any projects relating to last year's citation on comprehensive care planning at 11-94.1-39(b)(1); Expired medications at 11-94.1-46(n); and the unreliable call light system at 11-94.1-65(e)(8)(E). Again during this survey, the facility is being cited in these 3 areas. According to last year's plan of correction, the facility implemented a system to	4 088	I. The facility alleges it does maintain a quality assessment and assurance committee consisting of the director of nursing services: a physician designated by the facility; and at least 3 other members of facility staff who meets quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. . Regarding F279: Resident #116 has a comprehensive care plan addressing the use of a geri chair consistent with physician orders, reasons for use and appropriateness of such. . Resident #121 no longer resides in the facility. . Regarding F431: No residents were found to be negatively affected by this finding. . Regarding F463: Upon notification of the main shower call light not functioning batteries were replaced immediately and staff confirmed proper functioning. The one malfunctioning pager was replaced immediately upon notification and all 3 other pagers on the Hale Ho'olu unit were verified as functioning properly by staff. Hand bells were placed in the main dining room bathrooms until system could be reprogrammed. System was reprogrammed on 2/22/16. . II. Regarding F279: Any resident currently utilizing a geri-chair for any reason have had their medical record care plan reviewed. Care plans have been updated to appropriately reflect the use of a geri-chair including assessment, rationale, physicians orders, and release schedule to ensure the least restrictive device is used. Continued on page 2	03/17/16 03/25/16

C: AA 3/23/16 A

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4 088	Continued From page 1 maintain accurate, comprehensive care plans. The last plan of correction also stated they implemented processes to ensure medication audits occurred to avoid expired medications. Finally, processes were implemented to ensure the call light system was properly functioning. The NOS and DON acknowledged they did not have a "good preventive maintenance program in place". They further indicated that they've attempted to recruit more CNAs but haven't had persons interested. In reference to the long wait times and nurse staffing, the NOS stated she occasionally pulled call light records to see how responsive the staff is. She stated that she does not consistently monitor that activity. The facility failed to maintain the activities stated in their previous Plan of Correction for their last survey. Additionally, they failed to have systems in place to address quality issues such as environment, infection control, and sufficient nurse staffing.	4 088	Continued from page 1 Residents admitted within the last month were identified have had their care plans and interventions reviewed to ensure fall risk factors are identified and appropriate prevention interventions are in effect. . Residents who have sustained a fall in the past 30 days have had their records to review with a new falls assessment completed as necessary with care plans revised accordingly. . Residents who have demonstrated a change of condition for improvement have had their falls assessment and care plan interventions reviewed with appropriate action and revisions made accordingly. . Regarding F431: A review of all medication rooms, medication and treatment carts for any other opened and expired items was conducted with no other items discovered. . Continued on page 2-2	
4 123	11-94.1-27(12) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (12)The right to be fully informed in advance about care and treatment and of any changes in that care and treatment and the right to participate in planning care and treatment,	4 123	See page 3 of 43	

Continued from page 1 (4 088)

Regarding F463: All call bells were audited to assure proper functioning of call lights and proper functioning/programming of pagers on 2/19/16. Any call bells/pagers found to be mal functioning were immediately fixed. No other residents were found to be affected by this deficient practice.

III. Regarding F279: Restraint care plans will be reviewed quarterly at care plan meeting to ensure intended use is unchanged, necessity exists, change of condition warrants continued use. A therapy screen will be conducted at any time the resident's condition changes to ensure appropriateness of device used. 03/30/16

Falls care plans will be reviewed quarterly at care plan meeting to ensure interventions remain current and aligned with resident's current condition.

Any fall reviews will occur at morning clinical meetings with the interdisciplinary team (IDT) to ensure that a new falls assessment is conducted. Identified risk factors will be reviewed with appropriate prevention interventions implemented and care plan revisions completed.

MDS nurses and resident care managers (RCMs) will be further educated on comparison of RAI findings and falls assessment to ensure all risk factors have been reviewed prior to decision to proceed or not for falls care plan.

Regarding F431: Licensed staff has been in-serviced on requirements for medication expiration and destruction protocols. Newly hired licensed staff will have policy reviewed as part of their unit orientation. Night shift staff will be responsible for checking medication rooms, medication and treatment carts nightly and discard any undated or outdated medications.

Regarding F463: A preventative maintenance program was created based on manufacturers recommendations to address call light batteries, call light bulbs, call cords, call bell computer maintenance, pager batteries, and pager programming. An extra pager was programmed and placed at each nursing station to be available 24/7 to staff in the event that a pager malfunctions. A pager check will be conducted at the change of every shift where a call light will be pulled and pager functionality will be verified. Nursing staff were in-serviced on the availability of extra pagers on each unit and how/when to conduct a pager check. Maintenance staff will check the primary computer for the call bell system for any warnings 3x per week and address any concerns accordingly.

Quality assurance audits will continued to be conducted and reported at monthly performance improvement meeting until the following survey if 100% compliance has not been reached and maintained for 3 consecutive months.

IV. Random audits will be conducted monthly X 3 and quarterly X 3 of all identified areas from annual survey. Results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. 04/04/16

Responsible Party: Administrator and/or Designee

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4 123	Continued From page 2 unless adjudged incompetent or incapacitated; This Statute is not met as evidenced by: Based on Resident interview, staff interview, and record review the facility failed to create an environment that is respectful of the right for one resident in the Sample Survey to exercise her autonomy in making choices regarding aspects of her life at the facility. Findings Include: Cross Reference to 11-94.1-39(a) In an interview with Resident, R #195, on 2/16/2016 at 1:43 P.M. she stated that she was not able to make choices about how many times she showers per week. Resident stated, "they were supposed to give me a shower on Monday and Friday but they missed Monday so I told them I need one and they gave me one today". Stated that she has only had 3 showers since she arrived. On 2/17/2016 at 12:15 P.M. in a record review it was noted that the resident was on hospice care. Under preferences in care planning regarding showering the goal is listed as: Resident will have her daily preferences met. In a review of "Resident Shower Choice" form on 2/18/2016 at 9:19 A.M., the resident had listed she would like showers on Monday, Wednesday, and Friday in the evening. The form was completed for the resident on 1/19/2016. In the Activities of Daily Living, ADL, log for dates 1/18/2016 - 2/18/2016 there are documented showers for the following dates and times:	4 123	I. Resident 195 no longer resides at the facility. II. All shower preferences for current residents was conducted, documentation was updated as needed. No other residents were found to be negatively affected by this deficient practice. III. Resident room change procedure will be updated to include shower preferences procedure. Facility staff will then be in-serviced on the policy. All room changes within the first month will be audited to assure shower preferences are being met. IV. Audits will be conducted for shower preferences for any residents with room change monthly x3 then quarterly thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Director Nursing and/or Designee	03/18/16 03/22/16 03/30/16 04/04/16

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4 123	Continued From page 3 1/26/2016 showered between hours of 1430 and 2229. 2/12/2016 showered between hours of 0630 and 1429. 2/16/2015 showered between hours of 0630 and 1429. Documention revealed that resident was showered 3 times from 1/18/2016 through 2/17/2016, a period of 31 days.	4 123		
4 127	11-94.1-28(a) Resident accounts (a) In the event the resident or family member requests the facility to manage the resident's personal funds, an itemized account shall be made available in writing to the resident or the legal guardian or surrogate, and shall be maintained and kept current for the resident, including: (1) Written receipts for all personal possessions and funds received by or deposited with the facility; and (2) Written receipts for all disbursements made to, or on behalf of, the resident. This Statute is not met as evidenced by: Based on a review of residents' personal funds, staff interview and facility policy review, the facility failed to refund residents' personal funds within 30 days upon death of 4 of 10 residents who had trust fund accounts with the facility. Findings include:	4 127	I. Facility reimbursed 4 identified trustees by 3/11/16. II. Facility audited all residents with trust funds who have expired within the last 3 months and appropriate action taken as necessary. III. Facility business office was in-serviced on the policy regarding Trust Fund: Refund Process. Business office will review any expired residents within the facility weekly and initiate process accordingly. IV. A monthly audit will be conducted of all expired residents with trust funds to assure that the facility is executing its policy and procedure. Audit will be conducted monthly x3 months then quarterly thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Business Office Manager/ Designee	03/11/16 03/04/16 03/17/16 04/04/16

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4 127	Continued From page 4 On the morning of 2/19/16, a record review from August 2015 to January 2016 (last 6 months from survey date 2/19/16) of the residents' personal trust funds found 14 residents had trust funds with the facility. The facility failed to reimburse 4 trustees within 30 days of residents' deaths. An interview with the CFO on the afternoon of 2/19/16 revealed the facilty was "sometimes late" with reimbursement of trust funds to family members. A review of the facility's policy titled, "Trust Fund: Refund Process" with effective dated 1/1/09 found, "The Business Services Representative is responsible for ensuring that a refund is processed within 30 days of the resident's discharge date."	4 127		
4 128	11-94.1-28(b) Resident accounts (b) Upon request of each resident or legal guardian or surrogate, articles kept for safekeeping shall be released. This Statute is not met as evidenced by: Based on resident and staff interviews and facility policy review, the facility failed to ensure residents received their trust fund monies upon request. Findings include: An interview with Resident, R #8, on the morning of 2/17/16 revealed she was unable to get money from her personal funds account on weekends and holidays. The resident stated that she attempted to get her money last week and was	4 128	I. Upon notification facility assured resident #8 trust fund request was processed. Responsible Party: Business Office Manager/ Designee II. No other residents were found to affected by this deficient practice. Review of the facility concern log did not indicate any further concerns regarding trust funds. Emergency funds were found to be available to residents. Responsible Party: Business Office Manager/ Designee III. Facility staff were in-serviced on current policy and procedure to include but not limited to the business office. All current residents with trust fund accounts will be notified of our current policy. All future residents who sign up for trust funds with the facility will have policy reviewed with them by the business office. Responsible Party: Business Office Manager/ Designee Continued on page 6	02/17/16 02/17/16 04/01/16

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4 128	Continued From page 5 told she couldn't because the business office was closed. The R #8 compared this facility to another facility where she previously resided. The R #8 stated that she was able to get her requested money at the other facility whenever she asked for it. She then stated, "Over here, they didn't even come talk to me. I asked for my money the other weekend and no one came later, when the business office was opened." An interview with the Chief Financial Officer, CFO, on the morning of 2/19/16 revealed that R #8 was correct. She stated, "If a resident asks for money on Saturday, it'll wait until Monday. The staff will notify the business office then they would provide that money on Mondays." A review of the facility's policy titled, "Emergency Trust Fund (TF) Petty Cash" with effective date 8/29/11, noted, "It is the policy of the facility to have a standardized process in place whereby a resident has access to their trust fund (TF) monies (limited to $20 maximum per emergency withdrawal) during the evenings, weekends and holidays."	4 128	Continued from page 5 . IV. A random sample of trust fund residents will be audited to assure that the facility is executing its policy and procedure. Audit will be conducted monthly x 3 months then quarterly thereafter, results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Social Services/Designee	04/04/16
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention;	4 136	I. Resident # 116 has a comprehensive care plan addressing the use of a geri chair consistent with physician orders, reasons for use and appropriateness of such. . Resident # 121 no longer resides in the facility. . Resident # 3 had splint schedule assessed immediately and applied accordingly. Resident has been further assessed by physical therapy for any further contracture management with appropriate revisions taken. . All resident with splints had schedule pushed to Kardex. Staff have been educated on proper splint use and passive range of motion for resident #3. Splinting application and . Continued on page 7	03/17/16

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4 136	Continued From page 6 (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to ensure that 3 Residents received the appropriate care and treatment to attain and maintain their highest practicable ability (R #116 for restraints; R #3 for range of motion services; and R #121 for fall prevention). Findings Include: 1) In an observation on 2/16/2016 at 1:20 P.M. it was noted that R #116 was lying back in a geri chair watching television in the activity area. R #116 attempted to crawl out of the geri chair several times. Staff approached the resident each time and slid her back into position on the geri chair and told her to "stay there". In an interview on 2/17/2016 with Activity Aide #1 when asked how often the resident is in the geri chair, she stated "always, she always tried to get up in a wheel chair or high back chair, it was easier for her to get out". In an interview on 2/17/2016 with the Director of Nursing (DON), she stated that the resident is "at risk for falls, definitely restless, and she can get out of the wheel chair". She further stated that the resident can walk but "it takes two people to use the front wheel walker, the geri chair is more used for comfort because she has a wound on her bottom, she is very restless because she has	4 136	Continued from page 6 schedule have been updated on the Kardex and care plan accordingly. No other residents found to be negatively affected. Resident # 121 no longer resides in the facility. II. Any resident currently utilizing a geri-chair for any reason have had their medical record care plan reviewed. Care plans have been updated to appropriately reflect the use of a geri-chair including assessment, rationale, physicians orders, and release schedule to ensure the least restrictive device is used. Residents admitted within the last month were identified have had their care plans and interventions reviewed to ensure fall risk factors are identified and appropriate prevention interventions are in effect. Residents who have sustained a fall in the past 30 days have had their records to review with a new falls assessment completed as necessary with care plans revised accordingly. Residents who have demonstrated a change of condition for improvement have had their falls assessment and care plan interventions reviewed with appropriate action and revisions made accordingly. Resident's currently using splints or contracture management devices have had their care plans and treatment plans reviewed with appropriate action taken to ensure compliance with all recommended interventions. Staff have been educated on proper contracture management and schedule with Kardex and care plan updated accordingly. Residents admitted within the last month were identified have had their care plans and interventions reviewed to ensure fall risk factors are identified and appropriate prevention interventions are in effect. Continued on page 8	03/25/16

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4 136	Continued From page 7 anxiety and we are looking at that". In a record review on 2/18/2016 of clinical notes from R #116's admission on 1/02/2015, records showed that resident arrived from an acute hospital, alert and oriented x 1. The note stated that resident had multiple pressure ulcers (PU), Hypertension (HTN), malnutrition (chronic), Dementia with behavioral disturbance (chronic), cirrhosis of liver, peripheral venous insufficiency; atherosclerosis of aorta. In a record review of all clinical notes from admission (1/02/2015) through 2/01/2015 resident had no documented restlessness, discomfort, yelling out, or attempts to get out of bed unassisted. In a record review of a nursing note from 2/02/2015 @ 10:46 P.M. the first documented attempt of resident attempting to get out of bed (GOOB) unassisted was found. The note stated "Resident awake in bed. Resident made a few attempts to get out of bed (GOOB) unassisted. MD was called and order for geri-chair was received". In a record review on 2/18/2016 of MD order it was noted that a telephone order was recieved on 2/02/2016 for, "Geri Chair as needed, use of Geri Chair for periods of restlessness m/b attempting to get out of bed unassisted, confusion, or calling out". In a record review of nursing notes from 2/03/2015 @ 9:59 A.M. both written and verbal consent were received by Designated Power Of Attorney, DPOA, for the use of the geri-chair. The note states that it was "Explained to her what it is and what it's used for. She can use it when	4 136	Continued from page 7 . III. Restraint care plans will be reviewed quarterly at care plan meeting to ensure intended use is unchanged, necessity exists, change of condition warrants continued use. A therapy screen will be conducted at any time the resident's condition changes to ensure appropriateness of device used. . Falls care plans will be reviewed quarterly at care plan meeting to ensure interventions remain current and aligned with resident's current condition. . Any fall reviews will occur at morning clinical meetings with the interdisciplinary team (IDT) to ensure that a new falls assessment is conducted, care plan and interventions updated appropriately. Identified risk factors will be reviewed with appropriate prevention interventions implemented and care plan revisions completed. . MDS nurses and resident care managers (RCMs) will be further educated on comparison of RAI findings and falls assessment to ensure all risk factors have been reviewed prior to decision to proceed or not for falls care plan. . Resident's currently using splints for contracture management have been screened by therapy. Splint use and schedules for identified residents have been updated on the care plan, Kardex and reviewed with staff. Residents with contractures have been screened/reviewed by therapy for splints and splints will be ordered per therapy recommendations. . Upon discharge from therapy, therapist will bring recommendations to morning meeting for IDT discussion and appropriate resident specific interventions and care plan updates. Resident care managers (RCM's) will then in-service staff. . Splint usage will be documented through nursing assessment and the treatment administration record. . Continued on page 9	04/04/16

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4 136	Continued From page 8 she gets agitated and or whenever she wants to get out of bed and wants to participate with activities". In several record reviews from nursing notes dating 2/07/2015 through 2/19/2016 it was noted that resident had spent increasingly more time in the geri chair although she had few instances of trying to get out of bed (GOOB) unassisted, or periods of restlessness while in bed. In several of the nursing notes throughout this 1 year time span, documentation shows that resident is restless while in the geri chair, complaining of pain to her coccyx and back areas, and attempts to get up out of the geri-chair. In an interview with Nursing Operation Specialist (NOS) on 2/19/2016 9:52 AM, when asked what the Geri Chair does for resident she stated that the resident didn't do well in a wheel chair. She stated that the resident wishes to stay in the geri chair and becomes agitated when encouraged to get out of the geri chair. In a record review on 2/19/2016 a note from Activities was written on 1/15/2016 stating that resident continues to use a geri chair for comfort and positioning. In an interview with Nursing Consultant on 2/19/2016 10:15 A.M. she stated that there is no specific nursing care plan for the use of the geri chair but it is listed as an intervention under the care plan for pain. The intervention reads "Reposition and use geri chair for comfort". 2) Resident #3 was admitted to the facility on 12/11/09 with admission diagnoses including: persistent vegetative state; encounter for attention to gastrostomy; dysphagia; unspecified	4 136	Continued from page 8 IV. Random care plan, splint, and fall audits will be conducted monthly X 3 and quarterly X 3. Results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Director of Nursing and/or Designee	04/04/16

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4 136	Continued From page 9 convulsions; disorder of central nervous system; and retention of urine. During the Stage 1 observations on 2/16/16 and morning of 2/17/16 found Resident #3 has contractures to bilateral upper extremities and bilateral lower extremities. On the morning of 2/16/16 the resident was observed seated in a geri chair in the activity/dining room with two pillows one under each arm and crook of elbow. There were no splints applied. Interview with the Licensed Nurse (LN) on the morning of 2/16/16 confirmed Resident #3 has contractures to upper and lower extremities. Observation done on 2/16/16 and 2/17/16 found the resident did not have any splints or hand rolls. Resident #3 had two pillows placed under both his arms. On 2/17/16 at 10:11 A.M., 11:48 A.M., 1:54 P.M. and 2:30 P.M. observed resident in bed with no splints or handrolls applied. On 2/18/16 at 7:50 A.M., 8:54 A.M. and 9:15 A.M. observed resident in bed with no splints or hand rolls. Concurrent observation was done with the Unit Manager (UM) on 2/18/16 at 9:25 A.M. The UM confirmed the resident was not wearing splints and would check the "Kardex" for the schedule of the splints. Record review was done on 2/17/16 at 11:00 A.M. and 2/18/16 at 10:20 A.M., the review found a physician progress note dated 1/17/16 documenting Resident #3 with anoxic encephalopathy with tube feeding. A review of a comprehensive resident assessment tool with assessment reference date of 2/19/16 found in Section O. Special Treatments, Procedures and Programs, O.0500. Restorative Nursing Programs, Resident #3 was coded as 0 (zero) the number of days passive range of motion, active range of motion and splint or brace assistance	4 136		

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4 136	Continued From page 10 was performed in the last 7 calendar days for at least 15 minutes daily or if less than 15 minutes. Review of the resident's care plan found a plan to prevent worsening of bilateral upper extremity and bilateral lower extremity contractures. the interventions included the following: apply bilateral upper extremity splints on day shift starting at 0800; remove bilateral upper extremity splints on day shift at 1100; do passive range of motion prior to applying bilateral upper extremity hand/wrist splints; apply bilateral upper extremity splints on evening shift starting at 1400; and remove bilateral upper extremity splints on evening shift at 1700. On 2/18/16 at 9:25 A.M. an interview was done with Certified Nurse Aide (CNA). The CNA confirmed that he provides care to Resident #3. Inquired whether the resident has splints, the CNA replied the resident does not have splints. Further queried whether the CNA provides passive range of motion. The CNA replied a "little bit". The CNA reported that passive range of motion is provided in the shower and when the resident is turned while in bed. The CNA was asked which areas is passive range of motion provided, the CNA stated the shoulders and the rest of the body is "very restricted". An interview and concurrent record review was conducted with the UM on 2/18/16 at 9:40 A.M. The UM reviewed the "Kardex" and reported Resident #3 is to receive passive range of motion to bilateral upper extremities; hand and wrist splints to be placed on resident for three hours a day (0800 to 1100); remove all splints by 1100 and reapply from 1400 to 1700; and remove all splints by 1700 and check the skin for redness. The Kardex also includes placing an elbow pillow for 90 degrees flexion.	4 136		

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4 136	Continued From page 11 The facility failed to implement Resident #3's care plan (use of splints and passive range of motion services) to prevent worsening of contractures to the upper extremities. 3) A complaint was filed with the State Agency, SA, for R #121 and indicated multiple concerns including R #121 experiencing a fall while a resident in the facility. A closed record review found R #121 was admitted to the facility on 8/21/15 with diagnoses that included: Acute respiratory failure, Profound weakness, Severe malnutrition, and Severe sepsis. Upon admission, a "Falls Risk Evaluation" was completed with a score of "13". Scores greater than 10 were considered "High Risk". Resident #121 was discharged from the facility on 9/29/15 when she was transferred to an acute hospital for urosepsis. An interim care plan was created on 8/21/15 titled, "(Initial) Fall Risk", with the goal: No injury/falls. Interventions included: Assess for fall risk factors; Encourage to use call lights; and Instruct on safety measures. The interim care plan further indicated the resident was referred for Physical Therapy (PT). The care plan also noted, "Adaptive device: (left blank)". The onset date was 8/21/15. On the morning of 2/18/16 a closed record review found a 30-day comprehensive resident assessment tool with an Assessment Reference Date, ARD, of 9/18/15, indicated that R #121 was at risk for falls. The R #121 triggered as high risk for falls based on multiple factors which included: Physical limitations; On antidepressant medications; On hypnotic medications; On diuretic medications; and had internal risk factors	4 136		

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4 136	Continued From page 12 (neuromuscular and perceptual). The Care Area Assessment, CAA, on the MDS indicated a falls care plan would not be generated because the Resident: Did not have a history of falls; Doesn't attempt to get out of bed without assistance; Is participating in rehabilitation services (PT, OT) for increased strength; Is non-ambulatory and requires full staff assistance with transfer to and from her bed; and Is alert and aware of her own safety. The CAA indicated, "Due to her low risk for falls at this time, no need to care plan or continue. Refer to ADL care plan." According to the complaint filed for R #121, she experienced a fall on 9/19/15. The facility provided a copy of the incident report, IR, for R #121's fall on 9/19/15 which noted the resident was found in her room sitting on the footrest of her wheelchair in front of the TV. According to the IR, the resident was asked what happened, to which she replied, "I don't know what happened." The resident's buttocks were resting on the footrest of the wheelchair and she was sitting in her BM. The nursing assessment indicated the R #121 did not have injuries from the fall. Following the fall, a care plan was generated for Falls on 9/19/15 with the problem noted as, "Risk for falls due to weakness and poor trunk control." The interventions included the addition of a non-slip pad under the resident's wheelchair cushion to help prevent cushion from sliding. Another intervention noted, "Resident not to be left unattended while in wheelchair. Per husband's request he will supervise her while in house and take her for strolls." A falls risk assessment was not done after the resident fell on 9/19/15. An interview with the Nursing Operations Specialist, NOS, and Director	4 136		

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4 136	Continued From page 13 of Nursing, DON, on the morning of 2/18/16 at approximately 10:45 A.M., revealed the facility was supposed to complete another falls risk assessment after R #121 had fallen. From the assessments, the staff were supposed to generate an interim care plan until a comprehensive assessment was done. The NOS indicated that based on her risk for falls, a falls care plan should have been in place. The DON indicated that the resident became increasingly restless and had been experiencing loose stools. Upon admission, R #121 was mostly bed bound because she was very sick. After a few weeks, she got stronger and was up in her wheelchair more frequently. The DON acknowledged the change in condition for R #121 would have warranted the staff to review the care plan to ensure the appropriateness of interventions. When asked if the resident's fall was unavoidable, both the NOS and DON stated they could have done better at managing the resident's care.	4 136		
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on resident, family, staff member interviews; observations, and record reviews the facility failed to assure that there are adequate	4 148	I. The facility does provide sufficient staffing on a 24 hour basis to provide nursing care to all residents in accordance with their care plan. Resident #135 has had his/her needs met with no negative outcomes. . II. Call logs were reviewed by the facility for areas of concern including shift, unit, and room for patterns or trends. Identified patterns or trends have been individually addressed and will continue to be monitored ongoing. . III. All departments will educated on call bell response expectations. . Available agency staff have been utilized for any vacant shift. . Company sponsored CNA class begins on 3/28/16 with a projected 18 students enrolled. Continued on page 15	02/20/16 03/22/16 03/30/16

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4 148	Continued From page 14 staff to meet direct care needs, planning, evaluation, and supervision in a manner which promotes each resident's physical, mental, and psychosocial well-being thus enhancing their quality of life. Findings include: 1) In an interview with R #135 on 2/16/2016 at 10:32 A.M. when asked about sufficient staffing, the resident stated "no" he does not feel that there is sufficient staff to meet resident needs "I have to wait too long for them to answer my call light". The resident stated that he felt staff intentionally ignored him. When asked how long he usually has to wait for help he stated oh it's been up to an hour or more sometimes. Resident's wife also confirmed that staff often take up to 1/2 an hour to answer his call light. In a record review on 2/18/2016 at 7:00 A.M. of Vision Link Call Data of dates (1/17/2016 through 2/17/2016) for room 122, the records show the following times the resident pressed the call button and staff response time. 0-5 minutes = 194 calls 5-10 minutes = 77 calls 10-15 minutes = 42 calls 15-20 minutes = 20 calls 20-25 minutes = 19 calls 25-30 minutes = 6 calls 30-35 minutes = 9 calls 35-40 minutes = 10 calls 40-45 minutes = 6 calls 45-50 minutes = 2 calls 50-55 minutes = 2 calls 70-75 minutes = 1 call 95-100 minutes = 1 call In a family interview with daughter of (R)#83 on	4 148	Continued from page 14 Staffing is reviewed based on census and daily the nursing administration reviews the acuity and determines the need for additional staffing and admission capabilities for that day Staffing will be reviewed monthly for any projected shortages and agency staff assignments or classes will be proactively scheduled accordingly. % of resident and/or responsible parties will be interviewed via QIS staffing questionnaire weekly. Based on the questionnaire if a negative response is solicited the residents call light response time will be reviewed to determine any issues or patterns. % of call log response times will be reviewed by administration weekly for areas of concern or patterns with appropriate action taken as needed. V. Random staffing audits will be conducted monthly X 3 and quarterly X 3. Results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Director of Nursing and/or Designee	04/04/16

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4 148	Continued From page 15 2/16/2016 at 12:00 P.M. during lunch in the dining room, she stated "no they don't have enough staff, especially on weekends the (other residents) aren't eating and getting served - they can't help themselves". She stated that she comes to feed her mother lunch daily to make sure she eats and feels badly watching those around her not getting help. She stated that during the week there are more people around with managers and supervisors but they aren't around on the weekends. 2) Cross reference to F323 A complaint was filed on behalf of R #121, alleging the facility staff took long to respond to call lights. Resident #121 was in the facility from 8/21/15 through 9/29/15. At the time of survey, the resident was no longer in the facility. The facility printed the call light records for R#121 during her entire admission. The call light record provided the date and time the call light was activated and the length of time the resident waited before someone responded. A review of the call light record for R #121 over the duration of her stay in the facility found longer than reasonable wait times. The R #121 activated the call lights and often waited longer than 30 minutes for assistance. The extremely long wait times appeared to have occurred on the night shift. The following were the dates and times when R #121 waited an unreasonable amount of time for assistance: 8/28/15 at 2:23 AM - 41 minutes, 57 seconds; 8/27/15 at 4:25 AM - 41 minutes, 22 seconds; 8/31/15 at 1:55 AM - 48 minutes, 30 seconds; 8/31/15 at 9:07 AM - 40 minutes and 33 seconds; 9/3/15 at 3:26 AM - 50 minutes; 9/12/15 at 1:47 AM - 46 minutes; 9/12/15 at 3:55 AM - 96 minutes and 6 seconds;	4 148		

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4 148	Continued From page 16 9/14/15 at 12:59 AM - 46 minutes and 31 seconds; 9/18/15 at 12:51 AM - 69 minutes and 51 seconds; and 9/25/15 at 6:23 AM - 51 minutes and 10 seconds. On 9/6/15, R #121 activated the call light from the bathroom and waited 20 minutes and 18 seconds before someone responded to her. The resident was experiencing loose stools and often needed assistance getting cleaned up. A review of R #121's comprehensive resident assessment tool, with Assessment Reference Date, ARD, of 9/18/15 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10 of 15, indicating she was alert and aware. Resident #121 experienced a fall on 9/19/15 when the staff found her with her butt resting on the footrest of her wheelchair in her room at approximately 4:45 PM. According to the facility's investigation of the fall, the resident last voided and was repositioned at 2:55 PM. The resident was sitting on her BM. The call light record indicates the resident activated her bed call light at 4:03 PM on 9/19/15 and the response time was 18 minutes and 55 seconds. An interview with a Licensed Nurse, LN #5, on the morning of 2/18/16 found the census for the Pikake unit was 29 residents for a total of 30 beds. During the survey period, the LN #5 indicated that the Certified Nurses Aides (CNAs) to resident ratio was: 4 CNAs to 29 residents (1:7-8) during day shift; 3 CNAs to 29 residents (1:9-10) during evening shift; and 2 CNAs to 29 residents (1:14-15) during night shift. A Quality Assessment and Assurance (QAA) interview with staff was conducted on the morning of 2/19/16. The Nursing Operations Specialist,	4 148		

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4 148	Continued From page 17 NOS, stated she occasionally pulled the call light records. After reviewing the records, she would reeducate the staff. When asked about the staffing ratios, the Director of Nursing, DON, stated they looked at the acuity of the unit. The DON stated they projected staffing needs based on residents' needs and the amount of care they required. When asked about the ratio of CNAs to residents, the DON replied the staff worked in teams and helped each other. She further indicated that Nurses and Nurse Managers worked with the aides and answered call lights. 3) An interview with R #8 on the morning of 2/17/16 revealed she experienced long wait times for staff assistance. Her BIMS was 15/15. She said she thought the facility did not provide enough staffing on all shifts. She often used her call light and waited at least 10 minutes for a response. She further indicated that the staff would come in, turn off her call light, and say they would return later after they complete their current task. The R #8 was completely dependent on staff for assistance. Her diagnoses included Quadriplegia; [redacted]; and Diabetes Mellitus. A review of R #8's call light record found she occasionally waited an unreasonable amount of time after activating her call light. A review of R #8's call light record from 1/23/16 to 2/18/16 (survey date 2/19/16) found the following dates when she waited an unreasonable amount of time after activating her call light from her bed: 1/23/16, 6:28 AM - 46 minutes, 4 seconds; 1/24/16, 7:33 PM - 43 minutes, 24 seconds; 1/30/16, 6:31 AM - 51 minutes, 20 seconds; 2/1/16, 12:45 PM - 41 minutes, 17 seconds; 2/3/16, 6:04 AM - 56 minutes, 47 seconds; 2/3/16, 7:09 PM - 49 minutes, 16 seconds;	4 148		

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4 148	Continued From page 18 2/4/16, 7:15 PM - 41 minutes, 58 seconds; 2/4/16, 9:50 PM - 43 minutes, 50 seconds; 2/7/16, 6:01 AM - 66 minutes, 23 seconds; 2/8/16, 7:32 AM - 40 minutes, 24 seconds; 2/11/16, 6:54 PM - 68 minutes, 22 seconds; 2/11/16, 9:14 PM - 61 minutes, 9 seconds; 2/13/16, 7:03 PM - 48 minutes, 15 seconds; 2/15/16, 6:00 PM - 72 minutes, 51 seconds; 2/15/16, 7:09 PM - 48 minutes, 49 seconds; 2/15/16, 8:57 PM - 42 minutes, 16 seconds. 4) An interview with R #92 on the afternoon of 2/16/16 revealed she experienced long wait times for staff assistance. She stated she sometimes waited 20-30 minutes but wasn't sure. Her BIMS was 8/15. Her diagnoses included Diabetes Mellitus; Dementia; Hypertension; and Depression. A review of R #92' call light record from 1/18/16 to 2/18/16 (survey date 2/19/16) found the following dates when she waited an unreasonable amount of time after activating her call light from her bed: 1/21/16, 3:53 PM - 63 minutes, 33 seconds; 1/22/16, 7:35 AM - 49 minutes, 28 seconds; 1/27/16, 5:56 PM - 74 minutes, 53 seconds; 1/31/16, 7:39 PM - 50 minutes, 24 seconds; 2/6/16, 1:39 PM - 48 minutes, 38 seconds 5) In an observation of lunch in the dining room on 2/16/2016 at 12:06 P.M. several of the staff members were assisting residents to eat, including activity aids, managers, DON, and administration. In an interview with the Director of Nursing (DON) on 2/17/2016 regarding sufficient staffing she stated that "staffing is something we are working on, we have a lot of struggles because Windward College no longer has a (CNA) program. She	4 148		

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4 148	Continued From page 19 stated that they are trying to hire but "we have had so many new changes". She validated that they are short of CNA's and the assignments are usually 8-9 residents per CNA. When asked about resident acuity she stated that "we will assist as needed, we try to juggle it, it depends on behaviors". In an interview with Certified Nursing Assistant (CNA) #1 on 2/18/2016 at 11:23 A.M. regarding staffing, she stated that the CNA's are usually assigned 7- 8 residents daily "but we all help". She stated that "the days are busy". She admits that they are often "short staffed." In an interview with Ilima Nurse Manager (NM) on 2/18/2016 when asked about 24 hour Director of Nursing Coverage she stated that "yes we do have a DON on call 24 hours per day who also works full time. She stated that she felt they have enough nurses and CNA's. She stated that she works the floor as both a CNA and nurse role if they are short. Currently the Ilima unit has 27 resident with 3 CNA's for the day shift (9 residents assigned to each CNA). NM states that this is a typical day, the CNA's can only break one at a time. She also stated that "we are not at full census but the acuity is high". She admits that it is difficult for the staff, "they work hard". In an interview with LN #1 on 2/18/2016 she stated that today they have 29 residents on the unit, 4 CNA's, 1 treatment CNA, and 1 nurse to pass medications. She stated that if there are no sick calls the staff seems "adequate" - stated that it is helpful to have a CNA to do treatments. Stated that she does not work night shift where there is no extra help, but during the day the manager is helpful on the floor if needed.	4 148		

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4 148	Continued From page 20 In a record review of the schedule for 2/14/2016 - 2/20/2016 received from the staffing coordinator, the schedule shows the following staffing spread out for the 4 units: 14 CNA's Scheduled for day shift , 11 for evening shift, and 8 for night shift on 2/14 13 CNA's scheduled for day shift, 10 for evening shift, and 8 for night shift on 2/15 14 CNA's scheduled for day shift, 12 for evening shift, and 8 for night shift on 2/16 12 CNA's scheduled for day shift, 12 for evening shift, and 7 for night shift on 2/17 11 CNA's scheduled for day shift, 10 for evening shift, and 8 for night shift on 2/18 14 CNA's scheduled for day shift, 12 for evening shift, and 9 for night shift on 2/19 16 CNA's scheduled for day shift, 11 for evening shift, and 7 for night shift on 2/20	4 148		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and	4 149	I. Resident # 116 has a comprehensive care plan addressing the use of a geri chair consistent with physician orders, reasons for use and appropriateness of such. . Resident # 121 no longer resides in the facility. . II. Any resident currently utilizing a geri-chair for any reason have had their medical record care plan reviewed. Care plans have been updated to appropriately reflect the use of a geri-chair including assessment, rationale, physicians orders, and release schedule to ensure the least restrictive device is used. . Residents admitted within the last month were identified have had their care plans and interventions reviewed to ensure fall risk factors are identified and appropriate prevention interventions are in effect. . Residents who have sustained a fall in the past 30 days have had their records to review with a new falls assessment completed as necessary with care plans revised accordingly.	03/17/16 03/25/16

Continued on page 22

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4 149	Continued From page 21 summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to develop a comprehensive care plan for 2 of 30 residents (R #116 and R #121) in the Stage II sample. Findings Include: 1) In an observation on 2/16/2016 at 1:20 P.M. it was noted that (R) #116 was lying back in a geri chair watching television in the activity area. (R) #116 attempted to crawl out of the geri chair several times. Staff approached the resident each time and slid her back into position on the geri chair and told her to "stay there". In an interview on 2/17/2016 with Activity Aid #1 when asked how often the resident is in the geri chair, she stated she was "always" in the geri chair "she always tried to get up in a wheel chair or high back chair, it was easier for her to get out". In a record review of a nursing note from 2/02/2015 @ 10:46 P.M. the first documented attempt of resident attempting to get out of bed (GOOB) unassisted was found. The note stated "Resident awake in bed. Resident made a few attempts to get out of bed (GOOB) unassisted. MD was called and order for geri-chair was received".	4 149	Continued from page 21 Residents who have demonstrated a change of condition for improvement have had their falls assessment and care plan interventions reviewed with appropriate action and revisions made accordingly. III. Restraint care plans will be reviewed quarterly at care plan meeting to ensure intended use is unchanged, necessity exists, change of condition warrants continued use. A therapy screen will be conducted at any time the resident's condition changes to ensure appropriateness of device used. Falls care plans will be reviewed quarterly at care plan meeting to ensure interventions remain current and aligned with resident's current condition. Any fall reviews will occur at morning clinical meetings with the interdisciplinary team (IDT) to ensure that a new falls assessment is conducted. Identified risk factors will be reviewed with appropriate prevention interventions implemented and care plan revisions completed. MDS nurses and resident care managers (RCMs) will be further educated on comparison of RAI findings and falls assessment to ensure all risk factors have been reviewed prior to decision to proceed or not for falls care plan. IV. Random care plan audits will be conducted monthly X3 and quarterly X 3. Results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Director of Nursing and/or Designee	04/04/16 04/04/16

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4 149	Continued From page 22 In a record review of nursing notes from 2/03/2015 @ 9:59 A.M. both written and verbal consent were received by DPOA for the use of the geri-chair. The note states that it was "Explained to her what it is and what it's used for. She can use it when she gets agitated and or whenever she wants to get out of bed and wants to participate with activities". In a review of nursing care plans on 2/19/2016 it was noted that no care plan was implemented for the use of restraints although an order had been written for the use of restraints (geri-chair) and consent had been received from the family to use restraints. In an interview with Nursing Consultant on 2/19/2016 10:15 A.M. she stated that there is no specific nursing care plan for the use of the geri chair but it is listed as an intervention under the care plan for pain. The intervention reads "Reposition and use geri chair for comfort". 2) Cross reference to 11-94.1-30(5) Resident #121 was admitted to the facility on 8/21/15 with diagnoses which included acute respiratory failure, severe sepsis, and critical illness polyneuropathy. A Falls Risk Evaluation was completed on 8/21/15 which indicated she was at high risk for falls. An interim falls care plan was developed on 8/21/15 The R #121 experienced a fall on the afternoon of 9/19/15 while unattended in a wheelchair in her room. A falls care plan was created on 9/19/15. Another Falls Risk Evaluation was not completed for R #121.	4 149		

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4 149	Continued From page 23 An interview with the Nursing Operations Specialist, NOS, and Director of Nursing, DON, on the morning of 2/18/16 revealed that interim care plans were developed until a comprehensive assessment was completed. The NOS specified that interim care plans were generated from the assessments. The DON noted that R #121 spent most of her time in bed when she was first admitted. As she became more alert, she started getting up in her wheelchair. The DON further stated the resident was experiencing loose stools which caused her to be restless. The DON and NOS both agreed that a care plan for falls would have been appropriate for R #121. Additionally, the DON noted the resident's status had changed from mostly in bed to spending more time up in a wheelchair.	4 149		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observations, staff interview, and record reviews the facility failed to store, prepare, distribute, and serve food under sanitary conditions, putting residents at risk for pathogen	4 159	I. The alleged out of date items were discarded. The dates located on the items were open dates vs. the alleged use by dates. Sanitizer machine was verified by outside vendor to be in proper working order before next scheduled meal service on 2/16/16. Ice machine lid, two air conditioners, radio, fans in kitchen and side of steam table was cleaned. There were no residents found to be affected by this deficient practice II. Review of infection log reveals no residents were negatively affected by this deficient practice. All open items were checked for any expired products and appropriate action taken as needed. A quick guide for staff regarding food labeling dates was posted in kitchen. Sanitizer was monitored for proper ppm following service by outside vendor and verified by food services director to be in proper working order. Staff were in-serviced on cleaning schedules and expectation. III. Open food items will be checked daily by food services staff for any expired food items. Dietary staff to be in-serviced on policy Food and Supply Storage. Dietary Continued on page 25	02/20/16 02/20/16 03/25/16

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4 159	Continued From page 24 exposure and physical contamination of food. Findings include: In an initial tour of the kitchen on 2/16/2016 at 7:46 A.M., it was noted that a jar of opened jelly had a label with a "use by" date of 2/12/2016 and a prepared container of oyster sauce covered with plastic wrap with a "use by" date of 2/15/2016. Both items were expired. In an interview with the Dietician/Kitchen Manager, D/KM, regarding the expired items, she stated that the jelly actually has an additional 7 days after the use by date and the oyster sauce has an additional month after expiration date according the the Department of Health. In a record review of the dish sanitization log it was noted that there was no entry for 2/16/2016 although the sanitizer was currently running. When questioned about the monitoring of the sanitation the D/KM asked kitchen worker #1 if she had checked the Parts Per Million (PPM) of the chlorine sanitizer in the morning, to which she replied "yes, it was 100 PPM". When asked to re-test, the D/KM had a reading of 0 PPM twice. At that time the D/KM told the kitchen workers to wash the dishes by hand until the problem was fixed and left to contact Ecolab. In a record review of a daily cleaning schedule provided by D/KM for the kitchen it was noted that tasks were not completed on several days during the time frame: (February 1-15) * Daily cleaning of cooks counter, plate warmer - not done 6/15 days . * Wipe microwave - not done 7 out of 15 days * Wipe counter in dining room (after breakfast	4 159	Continued from page 24 . staff to be in-serviced on procedures in the event that sanitizer ppm reads out of range. Cleaning schedules were updated and revised to include daily, weekly, monthly and quarterly cleanings. Dietary staff to be in-serviced on updated cleaning schedules. . IV. Audits of dating and labeling, sanitizer ppm, and cleaning schedules will be conducted monthly x3 then quarterly thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Food Services Director and/or Designee	04/04/16

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4 159	Continued From page 25 and lunch) - not done 12/15 days * Wipe carts after breakfast - not done 12/15 days * Wipe carts after lunch - not done 10/15 days * Wipe and fill food counter and coffee station before breakfast - not done 6/15 days * Wipe utility fridge when checking stock - not done 6/15 days * Wipe cooks counter, plate warmer, and steam table (above and below)- not done 5/15 days * Clean coffee machine outside, wipe inside, send tray to be washed - not done 5/15 days * Wipe down blender counter - not done 5/15 days. * Sweep floors - not done 13/15 days * Wipe carts after lunch - not done 13/15 days * Clean cups, beverage cart after dinner, rinse juice machine nozzles - not done 15/15 days In a record review of the weekly cleaning schedule provided by D/KM for the kitchen it was noted that tasks were not completed by several staff for both weeks 1 and 2. These tasks included: Ice scoop/machine and spice table; wash rice/grain bins; wash thickener tubs; stove top burners and catch sheet; sweep/mop walk in fridge and freezer, downstairs coffee machine; prep (#3) refrigerator; remove contents, clean and fill cabinets; empty and wash all PC item tubs in staff/resident area; wipe racks (food prep rack and storage rack); wipe mixer; all blenders; clean cook cart; fridge #1; heavy clean food carts; 2 trash cans (dish room);fridge #2; heavy clean white carts; and clean bins under blender sink, and floor drain - none of these tasks were completed week 1 or 2 of February (survey entry date February 16). In an interview with D/KM on 2/16/2016, she	4 159		

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4 159	Continued From page 26 stated that all kitchen staff do a thorough, and deep cleaning monthly at their staff meeting. She stated that they do not have documentation of the monthly cleaning. In an observation during a second kitchen tour on 2/18/2016 with D/KM the following items were noted: - Ice Machine inner lid dirty - Per D/KM, she stated that the ice machine is checked quarterly and Pacific Ice comes to service every 6-months. There is no documentation of checking or cleaning the ice machine. Asked D/KM to use a clean cloth to wipe the upper inside of ice machine lid. Cloth was soiled with dark material after wiping inside of lid. - Two air conditioners and a radio located on a shelf near the food preparation line were dirty, caked with dark dust/fuzz and blowing towards tables. - 1 fan in kitchen blowing towards the clean dishes was dirty, caked with dark dust/fuzz. - 1 fan in kitchen blowing towards meal prep line was dirty, caked with dark dust/fuzz. - Sides of steam table caked with food particles During an interview with D/KM on the second tour, she validated that the fans/air conditioners were dirty and were supposed to be cleaned quarterly by maintenance. She also validated that the sides of the steam table were caked with food but stated "the steam table top is cleaned after every meal but the whole stove is cleaned once per month during the staff meeting".	4 159		

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4 197	Continued From page 27	4 197	I. No residents were found to be negatively affected by this finding.	02/20/16
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observation, interview with staff members and review of the facility's policy and procedure, the facility failed to ensure drugs were labeled in accordance with currently accepted professional principles and the expiration date when applicable. Findings include: On 2/18/16 at 9:00 A.M. concurrent observation was done with the Licensed Nurse (LN) on the Pikake Unit. The medication cart contained three inhalers (Beclomethasone/Qvar Inhaler) that was not labeled with a date the medication was first dispensed. The LN confirmed these inhalers are to be labeled with a start date and these three inhalers were not labeled. The LN was asked whether the Qvar Inhaler is discarded after 30 days. The LN was not sure whether the Qvar inhaler is to be discarded after 30 days from first usage. Further observation found an Advair Diskus labeled with a start date of 12/30/15 with a label to discard after 30 days, the label was blank. The LN acknowledged the diskus was past the discard date. On 2/18/16 at 9:50 A.M. concurrent observation was done with LN on the Maile Unit. The medication cart contained Spiriva inhaler which was labeled opened 1/28/16 with discard date of	4 197	II. A review of all medication rooms, medication and treatment carts for any other opened and expired items was conducted with no other items discovered III. Licensed staff has been in-serviced on requirements for medication expiration and destruction protocols. Newly hired licensed staff will have policy reviewed as part of their unit orientation. Night shift staff will be responsible for checking medication rooms, medication and treatment carts nightly and discard any undated or outdated medications. IV. Random medication expiration audits will be conducted of medication rooms, medication and treatment carts monthly X 3 the quarterly thereafter with results reviewed at performance Improvement Committee. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Director of Nursing and/or Designee	02/20/16 03/30/16 04/04/16

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4 197	Continued From page 28 11/16 and a Symbicort inhaler with open date of 2/2/16 and discard date of 5/2/16. The LN reported symbicort is discarded after 90 days from first use. A review of the "Medications with Special Expiration Date Requirements" document provided by the facility on 2/18/16 at 12:14 P.M. notes the expiration date for Advair Diskus for inhalation is 30 (thirty) days after removal from foil-pack. The Nursing Operations Specialist reported the expiration date for the Qvar follows the manufacturer's expiration date. The system for discarding inhalers was not consistent, the LN on the Pikake Unit was not aware of discard dates and the LN on the Maile Unit had knowledge of discard dates for the inhalers in the cart.	4 197		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observation and staff interviews, the facility did not implement practices to control or prevent infection in the long term care facility as well as the Adult Day Health shower room. Findings include: Based on observation and interview with staff	4 203	I. The facility does allege that there is an established and maintained an Infection Control Program. . Resident # 200 is not on the sample resident list therefore unable to determine who was affected by this deficient practice. . The pulse oximeter and storage area were thoroughly cleaned and sanitized. . Resident # 123 suffered no negative outcome from this practice. . LN#1 received education and counseling regarding infection control practices during skin care treatments. . Shower gurney on Maile was pressure washed and bleached. A new mat was ordered for shower gurney. Nursing staff on unit were in-serviced on appropriate use of disinfectant. . Continued on page 30	02/20/16

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4 203	Continued From page 29 members the facility failed to maintain an infection control program to provide a safe, sanitary and comfortable environment to prevent the transmission of disease and infection. Findings include: 1) On 2/17/16 at 8:30 A.M. observed the shower room on the Maile Unit has a shower gurney with reddish/brown substance on the white plastic pipes to the left side of the gurney and blackish substance on the pipes on the right side of the gurney. The blue mat atop the gurney had cracks in the plastic by the head area and cracks in the areas by the ventilation hole. Interview was done with a Certified Nurse Aide (CNA) on 2/17/16 at 8:35 A.M. The CNA was asked what the substances are on the shower gurney pipes. When the blue mat was moved to look under the mat, a malodorous scent was smelled. The CNA was not sure what caused the scent. Inquired how the gurney is sanitized, the CNA replied the gurney is sanitized between residents and a disinfectant in a red bottle is sprayed. The CNA was unable to locate the red bottle with disinfectant to identify the solution the facility uses to sanitize the equipment. On 2/17/16 at 12:10 P.M. an interview was done with the Housekeeping staff. Inquired when does the housekeeping staff sanitize the shower equipment, the staff member replied the Housekeeping staff does not sanitize the shower equipment, the CNAs will do the sanitizing. A second interview was done on 2/17/16 at 12:20 P.M. with another CNA. The CNA reported a disinfectant in a red bottle is used to sanitize the equipment for infection control. Inquired what is the process for using this sanitizer, is the solution	4 203	Continued from page 29 . Wash cloths were immediately removed from the shower area. . II. Pulse oximeters and storage areas for vital sign equipment were inspected and thoroughly sanitized as necessary. . All shared shower equipment was checked and addressed as appropriate. . All shower rooms where checked for any unlabeled wash cloths. . No residents were found to be negatively affected by this practice. . III. Review of the past 6 months of resident council minutes regarding infection control practices will occur with action plans developed to address. . Routine cleaning schedule will be conducted for pulse ox machine. . A shower equipment cleaning schedule to be created and maintained by environmental services staff. Schedule will also include checks by environmental services staff for equipment wear and tear to be addressed as deemed appropriate. Night shift staff will check each night to assure that disinfectant is stocked in designated area. . Nursing staff will be educated on infection control practices with equipment, storage areas, wash cloths and resident care. Vital sign equipment and storage areas will be placed on a routine cleaning schedule to ensure sanitation is achieved. . IV. Random infection control audits will be conducted monthly X 3 and quarterly X 3. Results of audit findings will be reviewed at facility Performance Improvement . Continued on page 31	02/20/16 04/04/16 04/04/16

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4 203	Continued From page 30 rinsed off, is the solution wiped off? The CNA replied the areas where the resident had contact is sprayed and was not clear whether the solution is to be rinsed off or wiped off or if there is a dwell time for the solution. The CNA deferred to the nursing staff. The CNA was unable to locate the red bottle with the disinfectant and commented that it is "usually always here". Interview and concurrent observation was done with the Unit Manager (UM) on 2/17/16 at 1:10 P.M. The UM acknowledged the substances on the shower gurney and the cracks in the plastic on the blue mat. Inquired what kind of disinfectant solution is used to sanitize the shower equipment. The UM initially went to the locked cabinet in the bathroom (toilets and lavatories) and found it was not stored there. The UM was able to locate the solution in the locked closet labeled "Janitor". The UM reported that the housekeeping sanitizes the shower equipment in the morning. The red bottle was located and there was no manufacturer's directions for use on the bottle. The UM was unable to provide instructions for use of the sanitizer. The facility failed to have a program/system to sanitize shared resident equipment. 2) On 2/17/16 at 8:40 A.M., an observation was made of the Maile shower room with a Certified Nurse Aide (CNA) and 2 surveyors. There were 2 nylon washcloths hanging from clothes pins in the shower room. The staff member was asked who the washcloths belonged to and staff member replied it is written on the label of the washcloth. She searched the labels of the washcloths and there were no names of residents or room numbers on the labels. The staff reported the	4 203	Continued from page 30 . Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. . Responsible Party: Director of Nursing and/or Designee	

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ANN PEARL NURSING FACILITY	45-181 WAIKALUA ROAD KANEOHE, HI 96744

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4 203	Continued From page 31 blue washcloth was for resident in Room 110-3 and not sure who the other washcloth belonged to. The staff member was unable to respond when asked how all other staff members would identify who the washcloths belonged to as there was no names on the labels. 3) Observation of medication pass during the morning of 2/17/16 found the Licensed Nurse taking vital signs for R #200. The Licensed Nurse brought the vital signs cart into the resident's room, took his blood pressure and placed the pulse oximeter on his finger. She returned to her medication cart and used a sanitizing wipe to wipe down the blood pressure cuff and the computer screen. She did not wipe the pulse oximeter until the surveyor asked if it was necessary. The LN then stated, "I forgot." She proceeded with using a sanitizing wipe to wipe down the pulse oximeter. After sanitizing the pulse oximeter, she placed it back into it's resting space. The resting space was noted to have a brown liquid type substance which had dried on the surface of the machine. The LN failed to wipe down the dried brown liquid prior to replacing the pulse oximeter. 4) On 2/16/2016 at 10:03 A.M. an observation was made of Licensed Nurse (LN) #1 performing skin care for (R) 123. Before starting (LN) #1 donned gloves, cleaned resident's coccyx area and applied moisture barrier, she then turned the resident on her back and applied moisture barrier to her peri area without sanitizing hands or changing gloves. When asked if gloves should be changed/hands sanitized between cleansing and treating coccyx area and peri area, she stated "yes, we usually do that", then changed her gloves.	4 203		

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4 203	Continued From page 32 5) An interview was done with the DON on 2/18/15 at 12:45 P.M., she acknowledged that during their spot checks there were staff who are not consistent with the facilities handwashing and infection control expectations. There was no documentation of a follow-up when the resident council raised concerns about wiping equipments in between residents' use for example toilet seats. The Administrator had a conversation among nurse managers but no surveillance since 4/2015. 6) Adult Day Health Program: A tour of the Adult Day Health facility was done with the Director on 2/19/16 at 7:50 A.M. The shower room used for clients noted a sharps container mounted directly above the sink. A towel dispenser was mounted directly above the sharps container. Observation made of the paper towel being dispensed, noted it touched the sharps container, thus contaminating the paper towel. Interview with the Nursing Operations Specialist at 8:15 A.M. acknowledged that it is an infection control issue.	4 203		
4 213	11-94.1-54(d) Sanitation (d) Every facility shall maintain an effective pest control program so that the facility is free of pests and rodents. This Statute is not met as evidenced by: Based on resident and family interview the facility failed to maintain an effective pest control program to keep the facility free of rodents. Findings include:	4 213	I. After resident concern was addressed at time of incident there were no other reported or observed issues. II. No residents found to be affected by this alleged deficient practice. There have been no other similar concerns reported during a 6 month lookback period. III. Facility pest control to be monitored daily by all staff and any observed pest issues to be removed immediately as well as verbalized to Administrator/Designee. Extermination provider contacted to tour facility to evaluate and provide recommended services for additional pest control. Monitoring for pests will be added to bi-monthly environmental rounds. Continued on page 34	02/22/16 02/22/16

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4 213	Continued From page 33 During a resident interview on 2/16/2016, R #135 stated that he had a problem with a mouse in his room for several days "but they finally caught it with a trap". The resident's wife arrived to visit and verified that she had also observed the mouse in the resident room. In an interview with the Vice President of Operational Support, VPOS, on 2/18/2016 he stated that Ecolab comes to the facility once per month on a routine basis, periodically sprays, sets traps, and lets administration know if there is any indication of pests or rodents. Stated that if they have a pest enter the building, they do contact Ecolab but also try to trap the pest immediately.	4 213	Continued from page 33 IV. Audit of pest management to be performed daily x1 week then bi-weekly x 3 weeks. Then monthly thereafter given no significant findings. Facility extermination services will be initiated with any observed or resident/family concerns. Results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Administrator and/or Designee	04/04/16
4 218	11-94.1-55(e) Housekeeping (e) All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair. This Statute is not met as evidenced by: Based on observation and interview with facility staff, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Findings include: 1) On 2/17/16 at 8:30 A.M. observed the "Resident Bathroom Only" restroom on the Maile unit. The floor tiles has gray spots by the sink and around the toilet. The beige baseboards has white substance on it and there was a drip mark on the tiles under the sink. The tiles and base area by the toilet has gray/black areas and the floor tiles closest to the wall is cracked. Observation of the shower room found floor and wall tiles with black substance on it. On 2/17/16	4 218	I. Review of infection and accident log confirmed that no residents were found to be affected by the deficient practice. II. There were no other residents found to be affected by this deficient practice. All fans and vents in the facility were checked for cleanliness and were cleaned as needed. All rails in resident bathrooms were checked for stability and were addressed as needed. Floor waxing and cleaning maintenance was initiated. Concerns identified with duct tape in dining room were addressed and rectified. The flaking and peeling paint were addressed to prevent paint from falling. III. On 3/14/16 a job offer and acceptance was made to an additional maintenance associate to assist facility with deficiencies related to baseboards, cracked tiles, wall repairs, painting, flooring repairs and stained flooring. An inventory of all fans and vents within the facility was conducted. A preventative maintenance log was created to assure proper maintenance and cleanliness of fans and vents within the facility. Facility to implement bi-monthly environmental services rounds to monitor for facility cleanliness and general maintenance needs. Continued on page 35	02/22/16 03/22/16 04/04/16

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4 218	Continued From page 34 at 12:10 P.M. concurrent observation and interview was done with the Housekeeping staff. The staff member was unable to identify the black substance on the shower tiles and was not sure whether this substance would come off or was a stain. The observation of the resident bathroom was done. The staff member reported the tiles needed to be striped and waxed again and not clear whether the white substance would come off the baseboards. The staff member commented that the tile is stained. 2) Observations on the morning of 2/17/16 found the paint of the ceiling by the resident bathroom on the Maile unit is peeling. Also, observed the ceiling paint is peeling and flaking above bed 1 in room 107, this resident has a tracheostomy, receives tube feeding and primarily bed bound. The ceiling in room 109-3 is cracked with peeling paint and a smattering of reddish substance. The ceiling in room 106 above beds 3 and 4 is cracked . The ceiling outside of the privacy curtain for bed 106-3 is scraped with peeling paint. A walk through was done with the Environmental Staff on 2/17/16 at 12:25 P.M. The staff member reported that the facility had solar panels installed and the drilling punctured holes in the roof which resulted in leaks. The plan is to wait until all the panels are installed and then repair the ceilings. However, the staff member confirmed the peeling paint above the resident in bed 107-1 needs to be scraped to prevent the paint from falling on the resident. 3) Observation was made on the Ilima Unit on 2/16/16 at 8:33 A.M. The paint on the door to Room 117 was scuffed and peeling.	4 218	Continued from page 34 IV. Audits of housekeeping and maintenance services will be conducted monthly x3 then quarterly thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Administrator and/or Designee	04/04/16

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4 218	Continued From page 35 4) On 2/16/2016 at 10:51 A.M., an observation of Resident, R #103 in room 115-3 was made. Resident was lying in bed with eyes closed, mouth open, a trachea attached to a concentrator, and was receiving nutrition through a feeding tube. On the floor next to resident's bed was a large black fan with vents on 3 sides. All of the vents were caked with thick dust/dirt, some of which was blowing out into the air. On a second observation of R #103's room on 2/18/2016 it was noted that the fan had not been cleaned and thick dust/dirt clumps were caked in all vents and blowing out into the room. In an interview with Environmental Service Worker (ESW) #1 on 2/18/2016 at 9:00 A.M., he stated that they do monthly cleaning to equipment such as "fans and electrical equipment". He stated that he didn't know if there was a log to document cleaning. When asked how long he has worked at the facility, he stated "3 months". When asked if he had logged any cleaning of fans or electrical equipment he stated "sometime I do log". Stated that he did not know where the log is kept. When asked if electrical items are checked annually or on a schedule, he stated "I have to ask my boss". ESW #1 validated that the fan was "very dirty and should be cleaned more". He then stated that they have no maintenance manager "so the Administrator is my boss". In an interview with the Vice President of Operational Support (VPOS) on 2/18/2016 at 9:40 A.M., he stated that they "inspect concentrators, suction and electrical equipment, and cords for UL stamps". He stated that they do not put inspection tags on electrical items. He stated that he did not know how often the electrical equipment is checked "but for sure on	4 218		

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4 218	Continued From page 36 admission". He was not aware of any cleaning log. He stated he would check to see if they have a Policy & Procedure (P&P) on safety inspection of fans, televisions (TV), or personal resident electrical items. In an interview with the VPOS on the afternoon of 2/18/2016, he showed me Nursing Station Service Repair Board that is located on the units (nursing stations). This is where nursing staff write down anything for maintenance to check or repair and the nurses will also call maintenance if it important. Maintenance checks the logs daily. Per VPOS there is no way to know if there is a problem unless it is reported. Stated they do not keep logs for routine maintenance and cleaning. 5) A facility tour was conducted with the Director of Operations, the outgoing Administrator, and the incoming Administrator on 2/18/16 at 8:25 A.M. The following were found: The shower vents on the Maile and Pikake wings were dirty and dusty; On both wings there were several rooms that the flooring needs cleaning and scrubbing especially under the toilet seats; Some of the baseboards on both wings need painting and repair; Some floor tiles were chipped and missing; The main dining area on the ground floor needs painting on ledge area. On the basement/secured floor the dining area had four duct tapes running across, and they are noted to be worn out. Some of the toilet rails in the main shower, dining room bathrooms, and rooms 2 and 5 were wobbly, the screws were not tighten. The entrance to room 2's bathroom the wall needs painting. An interview was done with the Director of Operations and she acknowledged that the facility	4 218		

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4 218	Continued From page 37 needs deep cleaning and repair. She mentioned that there was always a plan to renovate the facility. The facility's policy on Nursing: Maintenance Department with effective date of 10/01/2009 was reviewed. Under IV: General Facility Maintenance, it states- "The department will do on-going monitoring of the facility for areas needing repair and, if needed, will report to the supervisor for approval of the repairs needed."	4 218	I. Exit door was repaired immediately on 2/17/16 upon notification. No residents were found to be affected by the deficient practice. .	02/20/16
4 226	11-94.1-57(d) Life safety (d) Facilities shall have written procedures in case of fire, disasters, and emergencies. This Statute is not met as evidenced by: Based on surveyor review, the facility did not maintain fire exit doors, delayed egress mechanism, fire extinguishing system (kitchen range hood), and fire sprinklers. Findings include: Cross reference to Life Safety Survey, Citations K038; K043; K062; K069; K072.	4 226	II. All exit doors were immediately inspected for compliance. No other residents were found to be affected by the deficient practice. . III. A preventative maintenance program was created which will be conducted monthly which will also assure proper working order of all exit doors. . IV. Audits of exit door preventative maintenance will be conducted monthly x3 then quarterly thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Administrator and/or Designee	02/20/16 03/30/16 04/04/16
4 270	11-94.1-65(d)(7) Construction requirements (d) The facility shall have adequate toilet and bath facilities: (7) Each toilet and bath facility shall have a call system that permits the occupant to signal the nursing station in an emergency;	4 270	I. Upon notification hand call bells were immediately made available in adult day health toilet facility. There were no adult day health participants found to be affected by this deficient practice. . II. Review of accidents over the last 6 months yielded no results related to adult day health toilet facility. No adult day health participants were found to be affected by this deficient practice. Continued on page 39	02/20/16 03/21/16

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4 270	Continued From page 38 This Statute is not met as evidenced by: Based on observations and staff interviews, the facility did not ensure each toilet facility have a call system that permits the occupant to signal the nursing station in an emergency for one of 2 toilets for the Adult Day Health clients. Findings include: An observation was made of the bathroom/toilet room used by Adult Day Health clients on 2/19/16 at 9:25 A.M. Observations made during the survey noted clients from the program independently using the bathroom. Clients were observed walking independently or using a walker to the bathroom by themselves. There was no call system in the bathroom. Interview with a staff working in the Adult Day Health program confirmed there was no call system in the bathroom. Interview with the Director of Nursing on 2/19/16 at 9:40 A.M. acknowledged the finding.	4 270	Continued from page 38 III.Facility to research and purchase appropriate/permanent call light solution for adult day health toilet facility. Staff and Adult day health participants will be in-serviced on use of new system IV. Random audits will be conducted during adult day health operational times to ensure functioning call bell access monthly X3 then quarterly X3, thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Adult Day Health Director and/or Designee	04/04/16 04/04/16
4 277	11-94.1-65(e)(4) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (4) Single resident bedrooms shall measure at least one hundred square feet of usable space, excluding closets, bathrooms, alcoves, and entryways; This Statute is not met as evidenced by: Based on staff interview, the facility failed to have bedrooms measure at least 100 square feet in single resident rooms in 1 of 6 rooms on one of 4 units in the facility. Findings include:	4 277	Ann Pearl Nursing Facility has a current waiver for room size in Hale Ho'olu, please see attached.	02/20/16

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4 277	Continued From page 39 1) One room in Hale Ho'olu unit did not maintain the required square footage for the number of resident occupants. Room #1 measured 78 square feet. Room #1 was a private room for 1 person. Interview with the NOS on the morning of 2/18/16 confirmed that the room size for rooms 1 and 3 were not in compliance with the requirement for appropriate square footage. The NOS confirmed that the facility rooms remained as noted in the previous survey, and therefore were not in compliance with the requirement for appropriate square footage in Room 3 in Hale Ho'olu unit.	4 277		
4 278	11-94.1-65(e)(5) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (5) Multi-resident bedrooms shall provide a minimum of eighty square feet per bed of usable space, excluding closets, bathrooms, alcoves, and entryways; This Statute is not met as evidenced by: Based on staff interview, the facility failed to have bedrooms measure at least 80 square feet per resident in multiple resident bedrooms in 1 of 6 rooms on one of 4 units in the facility. Findings include: One room in Hale Ho'olu unit did not maintain the required square footage for the number of resident occupants. Room #3 was a multiple resident room.	4 278	Ann Pearl Nursing Facility has a current waiver for room size in Hale Ho'olu, please see attached.	02/20/16

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4 278	Continued From page 40 Interview with the NOS on the morning of 2/18/16 confirmed that the room size for rooms 1 and 3 were not in compliance with the requirement for appropriate square footage. The NOS confirmed that the facility rooms remained as noted in the previous survey, and therefore were not in compliance with the requirement for appropriate square footage in Room 3 in Hale Ho'olu unit.	4 278		
4 281	11-94.1-65(e)(8) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (8) Each resident shall be provided with: (A) A separate bed of proper size and height for the convenience of the resident and that permits an individual in a wheelchair to get in and out of bed unassisted; (B) A comfortable mattress with impermeable mattress cover, and a pillow with an impermeable cover; (C) Sufficient clean bed linen and blankets to meet the resident's needs; (D) Appropriate furniture, cabinets, and closets, accessible to and meeting individual resident's needs. Locked containers shall be available upon resident's request; and (E) An effective signal call system at the resident's bedside. This Statute is not met as evidenced by: Based on observation and staff interviews the	4 281	I. Upon notification of the main shower call light not functioning batteries were replaced immediately and staff confirmed proper functioning. The one malfunctioning pager was replaced immediately upon notification and all 3 other pagers on the Hale Ho'olu unit were verified as functioning properly by staff. Hand bells were placed in the main dining room bathrooms until system could be reprogrammed. System was reprogrammed on 2/22/16. II. All call bells were audited to assure proper functioning of call lights and proper functioning/programming of pagers on 2/19/16. Any call bells/pagers found to be malfunctioning were immediately fixed. No other residents were found to be affected by this deficient practice. III. A preventative maintenance program was created based on manufacturers recommendations to address call light batteries, call light bulbs, call cords, call bell computer maintenance, pager batteries, and pager programming. An extra pager was programmed and placed at each nursing station to be available 24/7 to staff in the event that a pager malfunctions. A pager check will be conducted at the change of every shift where a call light will be pulled and pager functionality will be verified. Nursing staff were in-serviced on the availability of extra pagers on each unit and how/when to conduct a pager check. Maintenance staff will check the primary computer for the call bell system for any warnings 3x per week and address any concerns accordingly. Continued on page 42	02/22/16 02/20/16 03/30/16

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4 281	Continued From page 41 facility failed to ensure that the call light system in the secured (HH) unit is functioning properly. Findings include: During the initial tour on 2/16/16 at 08:30 A.M. it was found that the call light in the main shower room of the secured/HH unit and room 5 were not working. Two maintenance staff members stated that the batteries need to be changed. There are 4 pagers in the secured/HH area. One of 4 pagers was not registering any calls from the residents. The Certified Nurses Aide, CNA, did not realize that her beeper was not working until surveyor asked the CNA who was calling. Currently, no preventative maintenance (PM) being done for the beepers except to change batteries at least once a month, the last time it was done was on 10/2015 and 01/2016. When surveyor pulled the call light in the bathroom of the main dining room it did not register on all four pagers. The Maintenance staff member and the Director of Operations acknowledged that the system was not set up to accordingly and that they will call the vendor. According to Licensed Nurse, LN #3, during change of shift, the staff do not check whether the beepers are working or not, it is a hand off from shift to shift. The policy on "Preventative Maintenance Schedule For Equipment" was reviewed. Under procedure 1: "The Environmental Services Supervisor is responsible for developing and maintaining a schedule of maintenance services to assure that all equipment are maintained in a safe and operable manner."	4 281	Continued from page 41 IV. Audits of call bell system and call bell system preventative maintenance will be conducted monthly x3 then quarterly thereafter results of audit findings will be reviewed at facility Performance Improvement Committee meeting. An ongoing semiannual audit through an intra-company process further validating compliance in this area. Responsible Party: Administrator and/or Designee	04/04/16

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