Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125014	A. BUILDING: _____ B. WING _____	03/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA RETIREMENT RESIDENCE	1434 PUNAHOU STREET HONOLULU, HI 96822

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4 000	11-94.1 Initial Comments A state relicensure survey was conducted at the facility from 3/20 - 3/24/2017. At the time of entrance, the resident census was 76.	4 000		
4 102	11-94.1-22(d) Medical record system (d) Records to be maintained and updated, as necessary, for the duration of each resident's stay shall also include: (1) Appropriate authorizations and consents for medical procedures; (2) Records of all periods, with physician orders, of use of physical or chemical restraints with justification and authorization for each and documentation of ongoing assessment of resident during use of restraints; (3) Copies of initial and periodic examinations and evaluations, as well as progress notes at appropriate intervals; (4) Regular review of an overall plan of care setting forth goals to be accomplished through individually designed activities, therapies, and treatments, and indicating which professional services or individual is responsible for providing the care or service; (5) Entries describing all care, treatments, medications, tests, immunizations, and all ancillary services provided; and (6) All physician's, physician assistant's, or APRN's orders completed with appropriate documentation (signature, title, and date).	4 102		

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Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR | 4/22/2017

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4 102	Continued From page 1 This Statute is not met as evidenced by: Based on interviews and a record review the facility failed to maintain medical records that were complete and accurately documented and readily accessible for 1 of 38 residents in the Stage 2 sample investigation. (Resident #94) Finding includes: On 3/24/17 at 9:52 AM a closed record review found Res #94 was admitted on 10/19/16 and expired on 11/2/16. Admission diagnosis included dementia, delirium questionable etiology and frequent falls. Res #94 had a Physician Order for Life -Sustaining Treatment (POLST) signed by the resident on 2/5/2014 for "Do Not Attempt Resuscitation/DNR, Comfort Measures Only, No artificial nutrition". On 11/1/16, res #94 had an episode described as petite mal seizure while receiving physical therapy. On 11/2/16 at 8:37 AM, Res #94 was assisted to the bathroom. During this time, "he appeared weak and skin color started to change (pale)". Blood pressure recorded at this time was 96/75, resident was "noted to have black tarry stool during am care". On 3/24/2017 at 10:44 AM. Staff #1 and #2 were queried regarding any documentation regarding why transfer was not done for hospital evaluation during the course of 13 days that led to the resident's decline and death. At 12:57 PM the same day Staff #1 stated that she had called Staff #8. Staff #8 stated he had spoken to family and had offered to send Res #94 out to be evaluated prior to admission but it was the family and resident's wish to remain in the facility. Family and resident did not want Emergency Room services. Staff #1 stated that there was no documentation of the decision discussed with Staff#8, family and resident in the resident's record.	4 102	4 102 Resident #94 Expired The facility has identified that this deficient practice has the potential to affect all residents in the Health Care Center (HCC), as all resident have a medical records that should be accurate and complete. An in-service and discussion with Staff #8 will take place, informing Staff #8 of the facility's obligation to maintain accurate and complete medical records. This includes proper and accurate documentation of: • History and physicals pertaining to the resident; • Documentation of formal conversations pertaining to the resident and/or the resident representative's care and choices; • Accurate and updated Care Plans, based on the resident/resident representative's choices; • Assessments and evaluations All practitioners who treat the resident's will be required to document content of their session with resident. The facility IDT will review the resident's record following a practitioner's visit, to ensure that documentation was completed. If the practitioner failed to complete documentation of the visit, within 24 hours of discovery, the Director of Nursing will place call to practitioner, requesting documentation of the visit.	4/25/17

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4 102	Continued From page 2 Resident medical records are legal documents that provide evidence of resident care should be accurate and complete.	4 102	4 115 On 3.21.2017 Res #71 was provided with a larger and louder bell, by staff. Staff requested resident to show a return demonstration that Res #71 could ring bell as needed, to call for assistance. Res #71 was able to do. Facility also contacted call system company, and ordered a longer call button cord, which will reach Res #71's lounge chair, in room. Res #71 is able to use call button to call for assistance, and does so, when in bed, and call button within reach. Longer call button arrived and installed in Res #71's room, staff will place call button next to resident, each time resident is sitting in her lounge chair.	4/21/17
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to adequately equip the resident to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 2 of 38 residents in the Stage 2 investigation sample. (Resident # 71 and #85) Findings include: 1) On 3/20/2017 at 9:20 AM observed Resident #71 (Res #71) sitting on the edge of a lounge chair in her room. Res #71's right leg was stretched out with her right hand on her right hip. Res # 71 stated, "help me, no one is responding to me. They used to". Prompted Res #71 to ring	4 115	Staff members were in-serviced regarding the placement of call button for Res #85. Staff members place residents call button, within reach of Res #85's range of motion, asking Res #85 to demonstrate ability to reach call button, prior to staff members leaving the resident's room. The facility identifies other residents who could be affected, as all residents who are able to use a call system, and attain the cognitive and physical ability to use call systems to call for assistance. To further assure that the deficient practice does not recur, the following measures have been instituted: 1) Staff in-service conducted, staff are required to ensure call light is within reach for each resident, able to use the call light system; upon each visit and exit of resident's room	4/20/17 4/20/17 Ongoing

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4 115	Continued From page 3 a bell located on a table next to her. Res #71 rang the bell and no one responded. Res #71 stated, "my pain". Observed the resident's call light attached to the resident's bed. The call light was activated for the resident. Staff #16 entered the room in response to the call light. Staff #16 asked the Res #71, what was wrong, if she wanted to go into her wheelchair or go to activity. During the observation there was no inquiry by Staff #16 of pain. On 3/21/2017 at 8:41 AM while standing outside and across from Res #71's room heard Res #71 ring her hand bell. Observed no staff respond to the bell ring. After three minutes, observed Staff #15 who was making her rounds walk into Res #71's room. A record review found Res #71's Care Plan Update Sheet dated 3/21/2017 stated, "was given 1 large (louder) bell in addition to usual small bell. Will use it on own discretion and staff will provide frequent checks to inquire on needs." At 8:52 AM the same day spoke to Staff #2 regarding observation on two separate days of Res #71 bell call system not being heard when used by the resident. Staff#2 acknowleded would review plan. 2) On 3/23/2017 at 7:16 AM observed Resident #85 in bed with a breakfast tray set up on the overbed table resting over the resident's lap. Resident #85 looked down at the tray and stated "they forgot to give me my oatmeal". Observed on the tray a strip of bacon, a small opened bowl of papaya chunks and no oatmeal. Observed the resident's call light under the resident's head pillow to the left of the resident. The location of the call light was pointed out to the resident. Resident #85 raised her right arm to reach up to the left of the pillow but was not able to reach the call light. Resident #85's care plan was reviewed	4 115	4 115 2) Prior to exiting, staff will ask resident to show return demonstration that resident is able to reach and grasp the call button. If the resident is not able to do so, the staff will reposition the call light until the resident can successfully return demonstrate. 3) If the resident is not able to use the call button, alternative call interventions will be attempted. Upon implementation of alternative call method intervention, IDT team members will test the alternative method to ensure that staff are made aware of the call and respond. If staff do not respond, alternative method will be tried and tested. 4) Upon shift change, staff are required to do rooms rounds, which includes checking placement of call light buttons for each resident. Staff document on their task sheets that call lights are within reach. Ongoing monitoring to ensure deficient practice will not recur, includes: • Weekly random audits, various shifts by the CNA Supervisor, checking 2 residents' rooms, in each of the 4 wings, to see if call light is in proper reach of the resident. Follow up with staff immediately, if the resident is not able to reach the call-light. • Review of call-light response times, weekly, by the IDT. • Weekly observations of staff, by the CNA Supervisor, to ensure that staff are following the corrective practice, upon exiting a residents room and at shift change.	Ongoing Weekly

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4 115	Continued From page 4 on 3/24/2017 and stated, "Needs assistance with ADLs/mobility due to increased forgetfulness and restlessness. 1. Call bell and personal items within reach at all times." The resident was not able to use the communication system provided to call for staff asistance. Residents must have an communication system to directly contact caregiver in their physical environment.	4 115		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations, staff and resident interviews, and record review the facility failed to ensure that all aspects of resident care needs are addressed for residents who require such services, consistent with professional standards of practice, and the comprehensive person-centered care plan for 3 of 38 residents in the Stage 2 sample. (Residents # 71, #98 and	4 136		

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4 136	Continued From page 5 #103) Finding includes: 1) On 3/20/2017 at 9:20 AM observed Resident #71 (Res #71) sitting on the edge of a lounge chair in her room. Res #71's right leg was stretched out with her right hand on her right hip. Res # 71 stated, "help me, no one is responding to me. They used to". Prompted Res #71 to ring a bell located on a table next to her. Res #71 rang the bell and no one responded. Res #71 stated, "my pain". Observed the resident's call light attached to the resident's bed. The call light was activated for the resident. Staff #16 entered the room in response to the call light. Staff #16 asked the Res #71, what was wrong, if she wanted to go into her wheelchair or go to activity. During the observation there was no inquiry by Staff #16 of pain. At 9:55 AM the same morning a concurrent review of the resident's medication Administration History for March was done with Staff #14. Res #71 was given a routine dose of Gabapentin at 9:48 AM. The last dose of Tylenol given routinely for pain was the night before at 19:00 PM on 3/19/2017. There was no Tylenol given as needed for the resident's complaint of pain that morning. Staff #14 was asked if she knew about the resident's pain this morning Staff #14 did not reply. When asked how pain is assessed for Res #71 Staff #14 responded, the resident grimaces and points. On 3/23/2017 at 8:51 AM observed Resident #71 in her room wearing a necklace and a larger bell at her bedside. At 13:50 PM the same day a concurrent Electronic Health Record Review (EHR) was done with Staff #5. Staff #5 had just completed Res #71's quarterly Minimum Data Set	4 136	4 136 For Res #71, a review of her pain medication regimen was requested by the facility, to resident's PCP. PCP reviewed medication and visited resident. Update to pain medication regimen made on 4/19/17. Facility will conduct a follow up Pain Assessment on 4/24/17 to measure the effectiveness of the medication adjustments. For Res #98, review of care plan interventions for fall reduction and safety was conducted on 3/22/17. Updated interventions were put in place on the Care Plan Update Form. For Res #103, review of resident's wandering behavior was completed by IDT. Based on reported observations, care plan was created and updated to address the behavior of wandering, for the safety of the resident, other residents in the community, and protect the dignity of other residents in the community. An episodic care was created to address this resident's wandering and have interventions in place, on 3/22/17. Facility has identified that a deficient practice in timely care planning; timely intervention implementation; and failing to provide timely intervention to pain could affect all residents in the community. To further prevent recurrence of this deficient practice, the facility: 1) Director of Nursing (DON), will provide an ongoing in-service to staff on the topic of Pain Management and Assessment, which includes information on identifying who is at risk; treatment and interventions; and ongoing monitoring	4/19/17 with follow up on 4/24/17; and ongoing 3/22/17; ongoing 3/22/17; ongoing 4/24/17; ongoing

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4 136	Continued From page 6 (MDS) pain assessment. For the MDS question, "Have you had pain or hurting at any time in the last five days?" the resident had answered "yes". The pain was occasional, the resident was not able to give a number but the resident's verbal description was "moderate". Staff #5 shared that Res #17 had not been having pain on previous assessments. A second review of the resident's medication Administration History for March found a new entry entered showing Res #71 received Tylenol 650 mg at 10:23 AM for complaint of pain that morning. An assessment note entered at 13:46 PM that afternoon on the effects of the Tylenol was written, "states feels better and pain Scale was 0". The time difference between administration and post administration assessment was nearly 4 hours. A careplan review for right hip pain states the intervention: "Pain is monitored when passing meds and when vital signs are taken". The review found no documentation for monitoring of pain when the resident was administered the Gabapentin or when the Staff #17 answered the call light on 3/20/2017. Failure to address the residents complaint of pain and to monitor for pain in a timely manner may affect the quality of care provided to the resident. 2) In the morning of 3/22/2017 Resident #98's record review found that Res #98 had two unwitnessed falls after admission to the facility, both causing injury. The first fall was on 1/28/2017 near the bathroom door and the second fall on 2/18/2017 in the bathroom. After the first fall on 1/28/2017 the resident's Care Plan Update Sheet, Action Plan stated: "Frequent visual checks, call light within reach, instructed resident to call for assistance, bed in lowest position, frequent checks/observation; assess pain level and medicate as needed; wellness	4 136	4 136 2) Staff in-service conducted to inform and educate staff regarding entry and answering call-lights of the residents; staff to inquiry and ask resident reason for call, rather than assume or suggest assistance. If resident voices having pain, staff are to inform LN on shift. 3) LN's provided with in-service, by DON, instructing and educating on PRN pain use, timely follow up, documentation, monitoring, and tracking. Any resident who has requested PRN pain medication for 2 consecutive days, will be reviewed and pain assessment conducted for follow up. A PRN pain use report will be run and reviewed weekly, LN's will inform QA Nurse and DON of PRN pain medication administration. In-service conducted for CNA's, LN's, and IDT members on 4/13/17; reviewing Incident Report completion, follow up and root cause analysis process, and the importance of timely interventions. Review and revision of facility's incident report form was conducted, revisions to form made, to gather more details regarding events, to assist in a more accurate root cause analysis. Incident Reports are reviewed within 24 hours of completion, with post-incident investigation, root cause/fall analysis, review of current interventions for effectiveness, and updated interventions implemented, by members of the IDT. Care plans are updated via Care Plan Update Form and dispersed to staff for immediate implementation. Fall Risk Assessments will be completed with each resident fall.	4/24/17; Ongoing 4/13/17; Ongoing 3/27/17; ongoing

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4 136	Continued From page 7 exercises for gait/balance." After the second fall on 2/18/2017 a review of the resident's Care Plan Update Sheet, Action Plan stated: "Daily dressing to scalp; neuro checks x 6 shifts; geomattress to side of bed and offer bedside commode". On 3/22/2017 a concurrent record review was done with Staff 4. Staff #4 stated a fall analysis was done after the 2/18/2017 fall and it was determined that the fall was unavoidable due to the resident's "ischemic changes in the brain" the resident "will continue to fall and be a risk for repeat fall". Staff #4 was not able to provide evidence of a fall care plan revision based on the current fall risk analysis and medical report. Later that morning Staff #4 provided a copy of an updated entry made to the resident's Care Plan Update Sheet dated 3/22/2017 at 10:23 AM for the fall that occurred on 2/18/2017. The revised fall interventions stated, "repeat falls and serious injury related to falls. Revised intervention #1: continue to provide supervision to limited 1 person assistance with ambulation with cane and provide frequent reminders and verbal cues to use cane at al times and to activate call light for assistance. Provide frequent visual checks every 2 hours to inquire on needs and offer/assist with toileting every 2 hours while awake and every 4 hours during sleeping time. Respond to calls promptly." On 3/22/2017 at 11:46 AM a concurrent review of the Fall Risk Analysis report after the 2/18/2017 fall was done with Staff #2. The analysis states resident fell in the bathroom with BM on the floor. The fall analysis documents Resident #98 had a scalp laceration and a skin tear to the left arm". In the "Probable Cause of Adverse Event" it documents, resident stated, "I fell down hitting my	4 136	4 136 DON conducted in-service on topic of wandering behavior; identifying who is at risk; and interventions to address behavior and promote resident dignity and safety Upon admission, a wandering assessment will be completed; and reviewed quarterly, annually, and at any significant change of condition; or observation of new wandering behavior. Incident report will be completed by staff, upon an observed event of wandering, and reviewed by IDT members within 24-hours, with implementation of interventions. The community will commit to a second QA Nurse position to conduct timely follow on incident report investigations and care plan updating. The facility will monitor and measure the corrective action and the effectiveness by: • Reviewing weekly, number of falls and wandering episodes (per resident); goal of reduction in number of occurrences. • Continued in-services held with staff regarding fall analysis, root cause analysis; and care planning, included in annual ongoing training, and included in new hire orientation. • Admin and DON will review all fall and wandering incident reports for timely analysis and implementation of the interventions, signing off Care Plan Update Forms, dispersed to staff.	4/24/17; ongoing 4/24/17; ongoing

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4 136	Continued From page 8 head on the floor". Staff #2 was asked to show evidence in the fall analysis of investigation on the cause of the laceration to the resident's scalp. Staff #2 stated there was BM on the floor but was unsure of the cause of the laceration. Timely fall interventions and finding the root cause of a fall related injury may contribute to a reduction in falls. 3) On 3/20/2017 at 11:47 AM observed Res #103 ambulating with a Front Wheel Walker (FWW) in the hallway. At 11:50 AM noon observed R #103 in the dining room seated. Res #103 stood up and was escorted back to her chair, stood up again and left the room unescorted; returned to room unescorted; stood up and walked around her table to another resident's table and was directed back to her own table by random staff; stood up and left the room again without using her walker; returned back to her seat; stood up again and left the room with her walker. At 2:30 PM on 3/21/2017 while standing with Staff #6 near the bed of Res #58, Res #103 walked into the room unescorted. Resident #58 was laying in bed furthest from the door. Staff #6 redirected Res #103 to her own room across the hallway. On 3/22/2017 at 12:08 PM met with the Staff #3 to do a care plan review. There was no care plan for wandering. On 3/22/2017 spoke to Staff #2 to discuss the observations and care plan findings. Staff #2 stated there should be an episodic care plan for wandering. Timely care planning and interventions may contribute to keeping the facility free from accident hazards for residents.	4 136		
4 173	11-94.1-43(a) Interdisciplinary care process (a) A comprehensive assessment shall be completed for each resident by an	4 173		

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4 173	Continued From page 9 interdisciplinary team at least annually and updated as appropriate, based on the resident's condition. This Statute is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to use the result of a fall assessment to develop, review and revise the resident's comprehensive care plan for one (1) of the 38 residents in the Stage 2 Census Sample. (Resident # 98) Finding includes: Cross reference to F 323 In the morning of 3/22/2017 Resident #98's record review found that Res #98 had two unwitnessed falls after admission to the facility, both causing injury. The first fall was on 1/28/2017 near the bathroom door and the second fall on 2/18/2017 in the bathroom. After the first fall on 1/28/2017 the resident's Care Plan Update Sheet, Action Plan stated: "Frequent visual checks, call light within reach, instructed resident to call for assistance, bed in lowest position, frequent checks/observation; assess pain level and medicate as needed; wellness exercises for gait/balance." After the second fall on 2/18/2017 a review of the resident's Care Plan Update Sheet, Action Plan stated: "Daily dressing to scalp; neuro checks x 6 shifts; geomattress to side of bed and offer bedside commode". On 3/22/2017 a concurrent record review was done with Staff 4. Staff #4 stated a fall analysis was done after the 2/18/2017 fall and it was determined that the fall was unavoidable due to the resident's "ischemic changes in the brain" the resident "will continue to fall and be a risk for repeat fall". Staff #4 was not able to provide	4 173	4 173 For Res #98, review of care plan interventions for fall reduction and safety was conducted on 3/22/17. Updated interventions were put in place on the Care Plan Update Form. Facility has identified that a deficient practice in timely care planning; timely intervention implementation; and failing to provide timely intervention to pain could affect all residents in the community. To further prevent recurrence of this deficient practice, the facility: In-service conducted for CNA's, LN's, and IDT members on 4/13/17; reviewing Incident Report completion, follow up and root cause analysis process, and the importance of timely interventions. Review and revision of facility's incident report form was conducted, revisions to form made, to gather more details regarding events, to assist in a more accurate root cause analysis. Incident Reports are reviewed within 24 hours of completion, with post-incident investigation, root cause/fall analysis, review of current interventions for effectiveness, and updated interventions implemented, by members of the IDT. Care plans are updated via Care Plan Update Form and dispersed to staff for immediate implementation. Fall Risk Assessments will be completed with each resident fall within 24 hours of event, and reviewed by IDT members, addressed pending results of the assessment, with updated interventions put in place.	3/22/17; ongoing 3/22/17; ongoing 4/13/17 3/27/17; ongoing

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	125014	A. BUILDING: _____ B. WING _____	03/24/2017

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4 173	Continued From page 10 evidence of a fall care plan revision based on the current fall risk analysis and medical report. Later that morning Staff #4 provided a copy of an updated entry made to the resident's Care Plan Update Sheet dated 3/22/2017 at 10:23 AM for the fall that occurred on 2/18/2017. The revised fall interventions stated, "repeat falls and serious injury related to falls. Revised intervention #1: continue to provide supervision to limited 1 person assistance with ambulation with cane and provide frequent reminders and verbal cues to use cane at al times and to activate call light for assistance. Provide frequent visual checks every 2 hours to inquire on needs and offer/assist with toileting every 2 hours while awake and every 4 hours during sleeping time. Respond to calls promptly." On 3/22/2017 at 11:46 AM a concurrent review of the Fall Risk Analysis report after the 2/18/2017 fall was done with Staff #2. The analysis states resident fell in the bathroom with BM on the floor. The fall analysis documents Resident #98 had a scalp laceration and a skin tear to the left arm". In the "Probable Cause of Adverse Event" it documents, resident stated, "I fell down hitting my head on the floor". Staff #2 was asked to show evidence in the fall analysis of investigation on the cause of the laceration to the resident's scalp. Staff #2 stated there was BM on the floor but was unsure of the cause of the laceration. Timely fall interventions and finding the root cause of a fall related injury may contribute to a reduction in falls.	4 173	4 173 The facility will commit to a second QA Nurse Position, to provide timely follow up on post incident investigations and timely care planning and care plan updates. The facility will monitor and measure the corrective action and the effectiveness by: • Reviewing weekly, number of falls and wandering episodes (per resident); goal of reduction in number of occurrences. • Continued in-services held with staff regarding fall analysis, root cause analysis; and care planning, included in annual ongoing training, and included in new hire orientation. • Admin and DON will review all fall incident reports for timely analysis (24-hour completion) and implementation of the interventions, signing off Care Plan Update Forms, dispersed to staff.	4/24/17; ongoing
4 203	11-94.1-53(a) Infection control	4 203		

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4 203	Continued From page 11 (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observations, staff interviews, and facility policy review, the facility failed to maintain a sanitary environment for staff and residents. Findings include: 1) During observation of medication pass on the morning of 3/22/17 at approximately 11:07 AM Staff (S) #14 had just used an Accucheck machine to check Resident # 33's blood sugar. The S #14 was observed using an alcohol swab to wipe down the Accucheck machine. S #14 was asked if the Accucheck machine was used for other residents, to which she replied, "Yes, it was used for other residents, not just [Resident #33]." The staff was asked whether the facility's policy/practice was to use alcohol wipes. She replied, "Yes, we use alcohol wipes to clean the Accucheck machines." An interview of Staff #2 on the morning of 3/23/17 at approximately 11:30 AM revealed the staff were expected to use the purple top CaviWipes to clean the Accucheck machines between residents. The Staff #2 stated that all staff were trained and should know the expectation. Staff #2 provided a copy of the facility's "Glucometer Clinical Competency" checklist, which is what they used for training staff and the	4 203	4 203 Staff (S) #14 was immediately corrected of observed Accucheck glucometer cleansing; and proper germicidal wipe was used. Staff (S) #14; DON conducted follow up competency testing to ensure staff member retained and proper practice. Unlabeled bedpan found in shared bathroom between Res #95 and Res #63 was immediately removed and new bedpan, properly labelled with resident's name, was placed in resident's room. Facility recognizes that all staff who use and administer CBG checks using a glucometer is at risk for deficiency, putting all residents who require CBG check to be completed at risk for infectious spread. To further prevent this deficiency from occurring, the DON conducted an in-service with all LN's, retraining on the best practice for proper glucometer cleansing. The facility will monitor this practice by: • DON will conduct random audits, observations of LN's monthly. • Quarterly competency test will be completed for all LN's, with return demonstration. • DON will train all new LN's and require accurate return demonstration for all new LN staff members, prior to administration to residents.	3/30/17 4/19/17 3/30/17; ongoing; quarterly Ongoing

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4 203	Continued From page 12 expectation for sanitizing the Glucometers. The checklist noted, "Wipes glucometer off with germicidal disinfectant wipe before and after testing." On the morning of 3/24/17, Staff #14 informed the surveyor that she was, indeed, trained to use the purple top CaviWipes. She stated she wasn't sure why she used the alcohol wipes. 2) On 3/20/2017 at 3:25 PM observed in the bathroom shower stall shared by 2 residents (Resident #95 and #63) an unlabeled bedpan and an unlabeled bath basin resting between the shower grab bar and the shower wall. Random Staff #7 was asked if that was the practice for storage of resident reusable personal equipment. Staff #7 stated no, the items should be labeled with the resident name for infection control. Unlabeled patient personal care equipment may facilitate transmission of infection among residents when used.	4 203	4 203 The facility recognizes that this deficient practice could affect all residents in the community. To prevent this deficient practice from recurring, the facility: • In-service of staff, educating on infection control practices, of shared rooms was conducted by CNA Supervisor. This included the proper practice of labelling resident's care and personal items. • CNA Supervisor will follow up with all new admission within 24 hours to ensure their items are properly labelled and stored. • Upon exiting the resident bathroom, after providing care, the staff were in-serviced to check for any unmarked resident personal items. If unmarked, immediately discard and replace with proper labeled item.	4/24/17; ongoing
4 249	11-94.1-65(b)(2) Construction requirements (b) The facility shall be fully accessible to, and functional for, physically disabled residents, personnel, and the public. (2) Temperature and humidity shall be maintained within a normal comfort range; This Statute is not met as evidenced by: Based on observations, staff interviews, and resident interview, the facility failed to provide comfortable and safe temperature levels for one resident interviewed in Stage 1 of the survey. (Resident #86)	4 249	To monitor the practice, the facility will: • CNA Supervisor will conduct weekly random audits of resident rooms, including the bathrooms, to ensure all items are properly labelled. If any items found unlabeled, immediate follow up with staff. • CNA Supervisor will conduct random staff competency skills test, weekly, observing and ensuring staff are checking for unlabeled bedpans upon exit from a resident's bathroom. If staff fail to do so, immediate follow up and in-servicing of practice will be conducted.	4/24/17; ongoing weekly

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4 249	Continued From page 13 Finding includes: On 3/21/2017 at 9:16 AM interviewed Res #86 on anything that affects the resident's comfort. Res #86 stated "Its always cold, I told them to adjust it, and they don't adjust it." On 3/22/2017 at 12:01 PM a concurrent visit was made with Staff #9 to test the temperature in Res #86's room. The temperature gun pointed to the wall where the room air conditioner is located registered at 56 to 57.5 degrees Fahrenheit. The temperature gun pointed to the back of the room furthest from the air conditioner registered at 72.5 degrees Fahrenheit, a 15 degree difference in readings. The air conditioning control was checked. It was set at low. Staff #9 stated the temperature would be adjusted. On 3/23/2017 at 9:58 AM an interview with Staff #1 was conducted. Staff #1 was informed of the temperature differences in Res #86's room. Staff #1 agreed, the temperature difference was big and would look into this. Comfortable and Safe temperature levels may affect the quality of life for residents.	4 249	4 249 Temperature of room of Res #86 was addressed on 3/22/17 and adjustments made to increase temperature of room. The facility has determined that the control of temperature, to comfortable level is important to the well-being of all residents in the facility. To prevent this deficiency from recurring the facility: • An in-service to staff will be conducted by CNA Supervisor and DON to staff in reporting resident concerns. All concerns should be followed up on, pertaining to the comfort of the residents • Any environmental issues affecting resident's comfort will be reported to the maintenance department via the facilities maintenance request software program. Maintenance department will address within 24-hours, any requests that pertain directly to the comfort of the resident To monitor the ongoing practice for temperature control and comfort, Maintenance department will conduct monthly room temperature audits to ensure the temperature fall in an acceptable range between 71 to 81 degrees Fahrenheit, or as desired by the resident(s) occupying the room. If temperature adjustments need to be made, it will be completed immediate, with follow up in 24 hours, to measure the adjustments.	3/22/17 4/24/17; ongoing 4/2017 ongoing monthly