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
	125051	A. BUILDING: _____ B. WING _____	02/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

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4 000	11-94.1 Initial Comments A relicensing sruvey was conducted by the State Agency from 2/7 - 2/10/2017.	4 000	**Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.**	
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 resident interviews, facility staff interviews and review of the facility's Admission Packet, the facility failed to provide residents with the ability to choose when they have visitors. Findings include: Resident interviews for Resident's # 311 and 313 on the morning of 2/7/17 revealed there were set visiting hours. Both residents reported the visiting hours were from 8:00 AM to 8:00 PM. An interview with Staff #158 on the afternoon of 2/9/17 revealed that residents were provided the visiting hours of 8:00 AM to 8:00 PM upon admission. Staff #158 reported that the facility staff were not strict with the visiting hours and	4 115	4 115 CORRECTIVE ACTION TAKEN The facility will provide residents with the ability to choose when they have visitors. IDENTIFICATION OF OTHERS Each resident residing and/or admitted to the facility will have a choice when they will have visitors. SYSTEMIC MEASURES The information sheet which indicates visiting hours will be removed from the admission packet. Resident residing in the facility will receive a letter informing them that they have the ability to choose when they have visitors. The right to choose when they have visitors will be reviewed during the resident and family council meeting. Staff will be in-serviced regarding residents right to choose when they can have visitors by March 27, 2017.	03/27/2017

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Scott L. Kanetani	Executive Director	3/3/2017

C: EP 3/6/17 Q

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4 115	Continued From page 1 they don't ask visitors to leave after 8:00 PM. An interview with Staff #7 on the afternoon of 2/9/17 revealed that visiting hours was discussed with residents upon admission. Staff #7 provided a copy of information included in residents' Admissions Packets which noted, "Visiting Hours: 8:00 AM - 8:00 PM". Staff #7 reported that the visiting hours were "just recommended". Staff #7 further noted they have a "No overnight" policy. The facility failed to allow residents the choice of visiting hours.	4 115	MONITORING IDT team or designee will conduct weekly random interviews with resident and/or family to verify understanding of the ability to choose when they have visitors. IDT team member or designee will bring results of all audits to the monthly Performance Improvement Committee meeting for the next 90 days.	
4 121	11-94.1-27(10) 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: (10)The right to manage the resident's financial affairs to the extent the resident is competent and capable of doing so; This Statute is not met as evidenced by: Based on interviews, observation, and admission packet review the facility failed to provide access to resident personal funds on weekends. Finding includes: On 2/7/2017 at 10:47 AM Resident #48 was asked if he was able to get his money from his	4 121	4 121 CORRECTIVE ACTION TAKEN The facility will provide access to resident personal funds on the weekend. IDENTIFICATION OF OTHERS Each resident who has a Resident Fund Management Service Account (RFMS) will be made aware of their access to their account on the weekends. SYSTEMIC MEASURES Admission facility information sheet will be updated to include availability of resident funds on the weekends.	03/27/2017

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4 121	Continued From page 2 personal funds account, including on weekends. Resident #48 responded he did not know. On 2/8/2017 at 3:27 PM Staff #205 was interviewed. When asked if residents at the facility have access to their accounts on weekends Staff #205 stated that access to accounts are during business office hours, if the resident needs cash for the weekend the business office can have it prepared by Friday. The information sheet given to residents on admission states: "Resident Trust Banking Hours: Monday - Friday: 9:00 AM - 4:00 PM. There was no information on the process for cash requests on the weekends. The facility information sheet provided to residents suggest residents personal funds are available during banking hours and not on weekends.	4 121	The facility process for dispersing resident funds on the weekend will be managed by the Activities Department or designee. Each resident will have access to their money should they request it on the weekend. The facility information sheet will include a process on how to access their funds on the weekend. Residents currently residing in the facility will receive a letter reviewing the process to access their funds on the weekend. The process will also be reviewed during resident and family council meetings. Staff will be in-serviced on the process to provide access to resident funds on the weekend on or before March 27, 2017. MONITORING The IDT team or designee will conduct weekly random interviews with resident and/or family to verify understanding of the ability to access resident funds during the weekend. IDT team member or designee will bring results of all audits to the monthly Performance Improvement Committee meeting for the next 90 days.	
4 154	11-94.1-40(b) Dietary services (b) All diets prepared for residents shall be: (1) Prescribed by the resident's physician, physician assistant, or APRN with a record of the diet as ordered kept on file; (2) Planned, prepared, and served by qualified personnel according to diet prescription. The current Hawaii Dietetic Association Manual or The Manual of Clinical Dietetics of the American Dietetic Association or both shall be readily available to all medical, nursing, and food service personnel; (3) All diets shall appropriately meet the nutrient, texture, and fluid needs of each resident; and (4) Therapeutic or special diets shall be planned by a dietitian and served accordingly as	4 154		

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4 154	Continued From page 3 prescribed by the resident's physician, physician assistant, or APRN. This Statute is not met as evidenced by: Based on observation, staff interviews and review of the facility's policies and procedures, the facility failed to ensure the services for enteral nutrition met the professional standards of quality for 2 of 24 residents (Res #72 and #1) in the Stage 2 sample. Finding includes: 1. On 2/07/2017 at 8:45 AM, during the initial tour of the Wailani unit, the nourishment refrigerator had two 1 Liter Glucerna 1.2 cal enteral nutrition (EN) containers dated "2/1" and "2/4/17 250 ml" for a resident whom Staff #164 said had been discharged. Staff #164 said the reason the containers were kept half used was because if the resident (Res #72) "eats under 50 percent of her meal, she gets this. These are hers." Staff #164 was asked when these were opened and how long used EN containers were kept for use as this resident was discharged. Staff #164 replied, "Yeah it's dated 2/1/17, this one is 2/4/17. They both should have been discarded after the initial connection, and the product label says it should be 48 (hours). But those 2 should have been discarded." 2. On 2/07/2017 at 2:18 PM, observation of Res #1 found she received EN via her gastrostomy tube (G-tube) as per the physician's order. There was a Jevity 1.2 cal EN container hung on an IV pole at her bedside and a green bag containing a flat top syringe. The green bag was labeled with the resident's name with 2/7/17 written on it.	4 154	4 154 CORRECTIVE ACTION TAKEN The facility will ensure the services for enteral nutrition meet the professional standards of quality. Enteral nutrition observed in nourishment refrigerator was discarded during survey. Resident #72 currently does not require enteral nutrition, resident is able to consume supplements by mouth. Resident #1 continues to require enteral nutrition. Resident #1 enteral nutrition will be labeled per the manufactures label indicating on the enteral nutrition. IDENTIFICATION OF OTHERS Residents that require the need for enteral nutrition will have their nutrition labeled per the manufactures label attached to the feeding container and discarded after opening per policy. SYSTEMIC MEASURES Licensed nursing staff will be in-serviced on the policy related to labeling of enteral nutrition and expiration date after opening by March 27, 2017.	03/27/2017

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4 154	Continued From page 4 However, the EN container did not have anything written on the label, but had been used. On 2/07/2017 at 2:27 PM, Staff #190 confirmed that he/she hung the Jevity 1.2 cal EN container for Res #1 at noon. Staff #190 acknowledged it was a "new one today" and began writing Res #1's name, date and start time of "1200" on the container's label. Staff #190 reiterated he/she knew the start time because, "I know it, I did it." On 02/10/2017 at 9:30 AM, Staff #158 produced a facility policy, "Tube Feeding Administration," which stated, "Procedural steps...10. Change feeding bag, tubing and syringe used for placement check...Label with date and resident's name." Another policy provided by the NHA on 2/9/17, "Feeding Tube Policy," stated, "...6) This facility has an operating procedure/protocol in place that directs staff on how to provide care and services related to feeding tubes...and clinical practice standards." According to Staff #158, Res #72 still resides at the facility and receives intermittent enteral nutrition as Staff #164 had stated. However, after reviewing the physician's orders and Medication Administration Record (MAR), Staff #158 said since Res #72 has not needed it, the two EN containers found in the unit's nourishment refrigerator should have been discarded. Staff #158 said, "Nurses have to follow what's on the label too (manufacturer's guideline) and for [Res #72], it should have been discarded after 24 hours because it's intermittent." Staff #158 also acknowledged for their policy which stated to have the resident's name and date on the label, he/she said it would include more than that as part of their clinical standards	4 154	MONITORING IDT team or designee will conduct daily audits to verify labeling of enteral nutrition is complete and accurate and there is no expired feeding in nourishment refrigerator for the identified resident. IDT team member or designee will bring results of all audits to the monthly Performance Improvement Committee meeting for the next 90 days.	

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4 154	Continued From page 5 of practice. Staff #158 said the license staff are to put the resident's name, room number, directions for use (ordered flow rate), date and start time. Staff #158 affirmed there are many residents on this unit who are on tube feeding and it is something the licensed staff should be doing. Staff #158 verified without accurate labeling on the container, there is room for error and the potential for bacterial growth from spoilage with no start time or date. The State Agency references the Journal of Parenteral and Enteral Nutrition, A.S.P.E.N. Enteral Nutritional Practice Recommendations, Bankhead, R., et al., Mar 12, 2009, pp 129-130: "D. Labeling of Enteral Nutrition...Practice Recommendations...3. All EN labels in any healthcare environment shall express clearly and accurately what the patient is receiving at any time...4. The EN label should be compared with the EN order for accuracy and hang time or beyond-use date before administration."	4 154		
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.	4 159	4 159 CORRECTIVE ACTION TAKEN The facility will ensure that food is prepared and distributed in a sanitary environment, and will ensure food is served in a sanitary manner to resident's in the dining room. AC vents were cleaned prior to survey completion.	03/27/2017

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4 159	Continued From page 6 This Statute is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure the food was prepared and distributed in a sanitary environment, and failed to ensure food was served in a sanitary manner to residents during dining. Findings include: 1. On 2/09/17 at 10:16 AM, a kitchen tour with Staff #100 was done. Staff #100 looked at the ceiling vent above the food steam table and identified an "AC vent." Staff #100 said, "it's discolored and blackened--shouldn't be like that. Should be white." After looking at the other similar ceiling vents in kitchen, Staff #100 confirmed all the vents in the kitchen needed to be cleaned. For the one beige vent, Staff #100 thought it "retracts hot air," and further said, "looks like dust. yeah, needs to be cleaned too." On 2/10/17 at 8:49 AM, during a interview with Staff #121, he/she stated that Staff #100 mentioned the kitchen vents and that they scrubbed and cleaned them. Staff #121 acknowledged it was never put on a preventive maintenance (PM) log, but stated, "It will be my new PM for ac vents." On 2/10/17 at 10:21 AM, during an interview with Staff #93, he/she said maintenance used to have their own cleaning schedule for the kitchen vents, but now there's new staff and could not recall when it was last done. Staff #93 stated going forward, if the vents were not maintained on a quarterly schedule, he/she will initiate a reminder request to maintenance to do the cleaning.	4 159	IDENTIFICATION OF OTHERS Residents residing in the facility will have their food prepared and distributed in a sanitary environment, and will ensure food is served in a sanitary manner to resident's in the dining room. SYSTEMIN MEASURES Staff will be in-serviced on proper infection control after disposal of debris onto the floor during meal service by March 27, 2017. Dietary staff will be in-serviced on reporting dusty equipment that requires maintenance or housekeeping to service by March 27, 2017. MONITORING Maintenance has established a monthly cleaning schedule for the AC vents in the kitchen area. NHA will complete random audits in the kitchen area for dusty equipment. IDT team member or designee will bring results of all audits to the monthly Performance Improvement Committee meeting for the next 90 days.	

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4 159	Continued From page 7 2. On 02/07/17 at 12:45 PM a dining observation was done in the main dining room. Observed Staff #10 take a tray off the serving shelf and walk to a random resident seated a table with other residents. While walking towards the table a quarter sheet paper fell off from the tray onto the floor. Staff #10 picked the paper off the floor and proceeded to place the tray in front the random resident. Without hand sanitizing Staff #10 placed the quarter sheet of paper on the center of the table then removed the wrap and lids covering the random residents food. Another resident seated at the same table grabbed the quarter sheet of paper resting on the table, Staff #10 took the paper from the resident's hand. Immediately after the observation Staff #10 was asked the hand sanitizing policy when picking the paper off the floor and serving a resident their meal. Staff #10 acknowledged the need to hand sanitize. Failing to hand sanitize after picking up an item off the floor then serving food to a resident and dirty vents above food prepartion are potential breaks in infection control practice.	4 159		
4 177	11-94.1-44(a) Specialized rehabiiltation services (a) The facility shall provide for specialized and supportive rehabilitation services, including occupational therapy, physical therapy, and speech therapy, according to the needs of each resident, either directly by qualified staff or through arrangements with qualified outside resources. Services shall be programmed to: (1) Preserve and improve the resident's maximal abilities for independent function;	4 177	4 177 CORRECTIVE ACTION TAKEN The facility will provide residents with reasonable accommodations to have their call lights within reach. Resident #91 and #48 continue to reside in facility and are provided with reasonable accommodations to have their call lights within reach. Resident #286 no longer resides in facility.	03/27/2017

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4 177	Continued From page 8 (2) Prevent, insofar as possible, irreversible or progressive disabilities; and (3) Provide for the procurement and maintenance of assistive devices as needed by the resident to adapt and function within the resident's environment. This Statute is not met as evidenced by: Based on observation, interviews, and record review the facility failed to provide residents with reasonable accommodations to have their call lights within reach. (Residents #48, 91, 286) Findings include: 1. On 02/07/17 at 10:37 AM observed Resident #48 in bed with limited mobility, only able to move the fingers on his right hand. There was no call light observed on or near the resident. A random staff was called into the room and asked to locate Resident #48's call light. The random staff located the resident's call light on the night stand. The staff person rested the call light near the resident's right hand. Resident #48 was able to move his fingers to press and activate the call light system. In the afternoon of 02/08/17 Staff #164 was interviewed on the procedures to make sure resident call lights are within reach. Staff #164 stated residents are checked at rounds and with every contact to be sure the call lights are within reach. On 02/08/17 at 5:03 PM Resident #48 was observed in bed with his call light again on the night stand. Shortly after observed Staff #113 going into the resident's room then leaving the room. When asked Staff #113 stated, "I just rounded with him, he is OK". Staff #113 was	4 177	IDENTIICATION OF OTHERS Residents residing in the facility will be provided with reasonable accommodations to have their call lights within reach. SYSTEMIC MEASURES Staff will be in-serviced on or before March 27, 2017 related to providing reasonable accommodations to have residents call lights within reach. MONITORING IDT team or designee will conduct audits 5 times per week to verify residents are provided with reasonable accommodations to have their call lights within reach. IDT team member or designee will bring results of all audits to the monthly Performance Improvement Committee meeting for the next 90 days.	

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4 177	Continued From page 9 asked if the resident's call light was within reach. Staff #113 reentered the resident's room, took the call light from the night stand and placed it next to the resident's right hand. Resident #48's record review found the resident requires extensive to total assist, is alert and able to make basic needs known. 2. On 02/07/17 at 2:25 PM observed Resident #91 in bed with the residents call light wedged between the mattress and side rail near the resident's head. When asked to located her call light Resident #91 made an unsuccessful attempt to locate the call light cord. Staff #156 was called into the room and asked to locate Resident #91's call light. Staff #156 stated a family member had just left and may have placed the call light there. Staff #156 placed the call light on the resident's chest and asked the resident to activate the call light to test. The resident pressed the call light and activated the system. Failure to assure call lights are within reach may deny residents the right to receive reasonable accommodation to their needs and preferences. 3. On 02/07/17 at 11:42 AM, during Resident #286's interview and room observation, it was found the resident's call light had been wrapped around the right upper bed rail and was out of the resident's reach. The resident had been sitting in her wheelchair on the left side of her bed prior to the interview. After the interview, Res #286 was asked about her call light and she realized she could not access it, and said, "Oh, it's over there." Staff #165 thereafter came into the resident's room and moved her call light and cord across the bed so the resident could have access it. As the call light had not been accessible for Resident #286 to use, it did not allow her to have the ability	4 177		

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4 177	Continued From page 10 to have her needs accommodated to the maximum extent possible.	4 177		
4 185	11-94.1-46(b) Pharmaceutical services (b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and director of nursing that: (1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs; (2) Is reviewed at least every two years and revised as necessary to keep abreast of current developments in overall drug usage; and (3) Has a drug recall procedure that can be readily implemented. This Statute is not met as evidenced by: Based on observation, interviews, and record reviews the facility failed to monitor the drug regimen to ensure that there was adequate indications of use for 1 resident of 6 in the Stage 2 investigation for unnecessary drugs. (Resident #60) Finding includes:	4 185	4 185 CORRECTION ACTION TAKEN The facility will monitor the drug regimen to ensure that there is adequate indication of use for antidepressant. IDENTIFICATION OF OTHERS Resident with orders for a psychoactive medication, drug regimen will be monitored to ensure that there is adequate indication for the use of the medication ordered. SYSTEMIC MEASURES Staff will be in-serviced on psychoactive medication monitoring, documentation and the facility Behavior Program by March 27, 2017. Initial Behavior monitoring forms will be completed by Social Service Department and distributed to nursing staff for appropriate documentation. The facility consultant pharmacist will review the behavior monitoring forms and evaluate efficacy or continued use of psychoactive medications.	03/27/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 185	Continued From page 11 On 02/07/17 at 2:34 PM observed Resident #60 sitting up in her bed with many personal items stacked around the bed and nearby wall. Resident #60 refused to be interviewed when asked. On 02/08/17 at 9:29 AM approached Resident #60 who was again sitting up in bed, when asked to be interviewed, Resident #60 again refused. At 10:29 AM on the same day a medication review found Resident #60 was on Citalopram (Celexa)10 mg every day for depression. A record review on 02/09/17 at 1:38 PM found Resident #60's care plans on psychotropic medication use and depression with approaches that included to monitor behavior and report any negative observations to MD. Staff #164 was asked to show documentation of the monitoring done by the facility for adverse reactions to Citalopram and the resident's behaviors of depression. Staff #164 showed a Behavior Monitoring Form for Res #60 written on the form was: "Celexa 10 mg daily and Depressed Mood, Withdrawn". There was no documentation on the form to show staff had been monitoring for signs and symptoms of the medication or behavior symptoms of depression. Staff #164 shared a form titled "Skilled Medicare Documentation" and an entry for Resident #60 that stated, "Document behavior PRN with episode: Depression." Staff #164 stated documentation for depression is only as needed if the behavior occurs. On 02/09/17 at 2:08 PM a concurrent record review and policy review was held with Staff #204. The review found the following entries: 12/29/2016 refused novolog and lantus, many attempts to persuade resident but kept refusing; 2/7/17 refused to be changed, didn't want to be bothered; and 2/8/2017 refused to have nails	4 185	MONITORING IDT team or designee will conduct weekly audits of Behavior monitoring logs and documentation for adequate indication of use of medication ordered. IDT team member or designee will bring results of all audits to the monthly Performance Improvement Committee meeting for the next 90 days.	

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	125051	A. BUILDING: _____ B. WING _____	02/10/2017

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4 185	Continued From page 12 trimmed, fingernails long and thick. Staff #204 shared a monthly Behavior Summary log which documents resident behaviors. For January 2017, Resident #60's entry on the log was "no changes since last review". When asked if the behavior entries documented in the nursing notes should be reported on the monthly Behavior Summary Staff #204 stated these are behaviors the resident always displays. On 02/10/2017 at 9:05 AM met with Staff #88 and reviewed the Behavior Monitoring Form and monthly Behavior Summary for Resident #60. When it was pointed out that the monitoring form was blank; the behavior summary did not report incidents of depression; and there was no documentation monitoring adverse reactions to the Citalopram, Staff #88 acknowledged there was no monitoring. The facility's failure to monitor for symptoms of depression and adverse reaction to Citalopram (Celexa) a psychoactive medication, may result in the unnecessary use of the drug.	4 185		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observations, staff interviews and facility policy review, the facility failed to maintain a safe, sanitary environment for residents.	4 203	4 203 CORRECTIVE ACTION TAKEN The facility will maintain a safe, sanitary environment regarding shared equipment. IDENTIFICATION OF OTHERS Resident residing in the facility will have a safe and sanitary environment maintained.	03/27/2017

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4 203	Continued From page 13 Findings include: 1. On the afternoon of 2/9/17, observations of the shower rooms on Unit 1 found several shower chairs and gurneys. One shower chair on Unit 1 had brown and yellow substances on the inner rim of the shower seat. An interview with Staff #156 on the afternoon of 2/9/17 at approximately 1:30 PM revealed that she disinfected shower chairs between residents using a Cavi Wipe. She was unable to show the surveyor which Cavi Wipe was used. Another staff member walked by and Staff #156 asked Staff #23 about disinfecting the shower chairs. Staff #23 stated they used the "Heavy Duty Alkaline Bathroom Cleaner" or the "pink spray" (due it's pink color). Staff #23 stated they used the pink spray to spray the shower chair and wait about 1 minute then rinse it off and dry the chair. Interview of Staff #15 on the afternoon of 2/9/17 at approximately 1:45 PM revealed she, too, used the same pink spray between residents. She allowed the solution to remain on the surface of the chair for "a few seconds" then run hot water to rinse and towel dry. On the afternoon of 2/9/17 at approximately 2:00 PM, observation of the shower chairs on Unit 2 found the chairs/gurneys were also stored in the shower rooms. An interview of Staff #41 on Unit 2 at approximately 2:30 PM revealed she used the "pink spray" on the shower chairs and leaves it on for an unspecified amount of time. While waiting for the "pink spray" to sit on the shower chair, Staff #41 will go to the resident's room and change the linens/make the bed. She then returns to the shower chair, runs hot water over it then towel dries the chair before beginning with the next resident.	4 203	SYSTEMIC MEASURES Staff will be in-serviced on the disinfecting and sterilization of shower equipment per the manufactures recommendation by March 27, 2017. Licensed nursing staff will be in-serviced on hand hygiene procedure during medication administration by March 27, 2017. MONITORING Nursing administration will perform weekly medication administration audits to observe for proper hand hygiene procedure during medication administration. IDT team will conduct weekly interviews of staff and audits to verify proper disinfecting and sterilization techniques of shower equipment.	

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4 203	Continued From page 14 An interview with Staff #163 on the morning of 2/10/17 at approximately 9:30 AM, revealed she wasn't sure which solution was used to clean shower chairs/gurneys. Staff #163 provided the oversight for the facility's infection control program. Staff #163 stated that she needed to check with the Housekeeping staff to find out. She was sure that the nursing staff cleaned the shower chairs between residents but was unable to state which chemical was used. An interview of Staff #100 on the morning of 2/10/17 at approximately 10:00 AM revealed that staff were required to use the "pink spray" on the shower chairs and gurneys after each resident. The solution is required to stay on the chair/gurney surface for at least 10 minutes then rinsed and wiped dry. Staff #100 reported the Housekeeping staff also sanitized the shower chairs/gurneys twice daily. A review of the facility policy on the morning of 2/10/17 at approximately 11:00 AM found a general policy titled, "Cleaning/sanitizing, Disinfection & Sterilization" and noted it was from "Infection Control Manual, May 2015". The document noted, the purpose: "To provide supplies and equipment which are adequately cleaned and disinfected". The policy: "Clean supplies and equipment immediately after use." Staff #163 also provided the manufacturers recommendations for the "Heavy Duty Alkaline Bathroom Cleaner and Disinfectant" which noted, "Allow a 10 minute contact with the surface. Remove solution and entrapped soil with a clean, wet mop, cloth or rinse to drain". The facility staff, including the staff member overseeing their infection control program, were unclear on which disinfectant to use and the	4 203		

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4 203	Continued From page 15 duration for contact time. The facility failed to maintain sanitation with shared resident equipment. 2. Observation of medication pass on the morning of 2/9/17 at approximately 8:30 AM found Staff #117 passing medications to resident on Unit 2. Staff #117 was observed pushing the medication cart from one side of the hallway to the other side. She then pulled keys out of her pocket, opened the medication cart and opened the medication binder. Staff #117 took out the resident's medications and began popping the pills out of the blister packs without first sanitizing her hands. After popping all the pills into a medication cup, Staff #117 was observed opening 2 capsules of medications and pouring the each capsule's contents into a small medication cup which was half filled with water. An interview of Staff #163 on the morning of 2/10/17 at approximately 9:30 AM revealed Staff #117 should have sanitized her hand before popping the medications out of the blister packs. A review of the facility's policy titled, "Policies for Medication Administration" noted, "Follow hand hygiene protocol before and after each administration of medication".	4 203		