Hawaii Dept. of Health, Office of Health Care Assuranc						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B MINO	RECEIVED			
		125023	B. WING		02/1	10/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, 27000 PMAR 15 A 11: 21		
LANAI C	LANAI COMMUNITY HOSPITAL 628 7TH STREET LANAI CITY, HI 96763					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	STATE OF HAWAII	NI.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACHON SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	COMPLETE DATE
4 000	11-94.1 Initial Comr	nents	4 000			
4 152	facility from 02/08/1 entrance, the censu 11-94.1-39(e) Nursi	g survey was conducted at this 7 to 02/10/17. At the time of s included 7 residents. In g services In policies and procedures	4 152	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOR THOSE RESIDENTS FOR THOSE RESIDENTS FOR THE DEFICIE PRACTICE: The physician of Resident #4 was notified of the medication error on 2/10/2017 and a clarification was obtained. An event report was completed 2/10/2017 by the nursing staff and submitted to Director of Nursing / Assistant Administrator, who contacted the Administrator that same day.	e on order on o the	2/10/17
	manual that is kept current nursing and approved by the me the person respons The policies and pro- be limited to:	current and consistent with medical practices and dical advisor or director and sible for nursing procedures. Excedures shall include but not cedures for personnel to	•	HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRAC AND WHAT CORRECTIVE ACTION WILL BE All residents were at risk of being affected by the deficient practice of not having adequate measurable to assure that they receive medications appropriately as ordered. A review for accuracy ordered medications against the medication administration records for residents was completed.	TICE TAKEN: he ures in y of all	2/24/17
	(B) Notification and other persons represent; and (C) Arrange hospitalization, or other persons represents the pe	ments for transportation,		WHAT MEASURES WILL BE PUT INTO PLAC WHAT SYSTEMIC CHANGES YOU WILL MAK TO ENSURE THAT THE DEFICIENT PRACTIC NOT RECUR: The correct process for discontinuing medicatic reviewed with staff and begun on 2/24/2017 and expected to be completed by 3/10/2017 – this in the requirement for each staff to review new phyorders from the prior sheet to validate the proper transcription of physician orders, 2) the modification record, ar requirement for review / modification for accura	CE WILL ons was d is ncludes 1) ysician er ation of nd 3) the	2/24/17 3/10/17
	resident's needs and documentation; and (3) Medication or dr	ug administration procedures		signature of staff prior to initiating a pre-printed medication administration record from the remo pharmacy. The Long-Term Care Coordinator re include an extra review medication administration records at the beginning of each month to assuraccuracy / make necessary corrections and conevent reports as needed. Results of these audits shared in real-time with the Director of Nursing Assistant Administrator for appropriate action.	te eview will on re nplete ts will be	4/7/17
	This Statute is not n Based on record rev facility failed to accur	net as evidenced by: iew and staff interview the		HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The Long-Term Care Coordinator will report the of the audits at quality assurance meetings and Director of Nursing / Assistant Administrator will event reports and actions taken.	the	4/12/17
Office of Health Care Assurance LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						
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PRINTED: 02/21/2017 FORM APPROVED

Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING 125023 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 628 7TH STREET LANAI COMMUNITY HOSPITAL LANAI CITY, HI 96763 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 4 152 Continued From page 1 4 152 physician's order for 1 of 6 (Resident #4) residents in the Stage 2 sample list. Findings include: On the afternoon of 02/09/2017 Resident #4's (Res #4) medical record was reviewed. During medical record review, there was a physician's order written on 1/21/17 to "DC Bactrim DS". The Medication Administration Record (MAR) was reviewed and revealed that the medication was D/C'd on 1/22/17. However, the February 2017 MAR showed that the resident was still receiving Bactrim DS daily at 0630 AM from 02/01/17 -02/09/17 in which the resident received 9 extra doses of Bactrim DS. SM#3 was interviewed and shown the January and February 2017 MARs and doctor's orders and he stated "That's an error." Then he phoned the doctor and received an order, "To restart Bactrim DS 1 po daily on 02/09/17 at 1349". In summary, the facility failed to follow doctor's written order to discontinue Bactrim DS for Res #4. 4 173 11-94.1-43(a) Interdisciplinary care process 4 173 (a) A comprehensive assessment shall be completed for each resident by an 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 record review and staff interview the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 6 (Residents #6 and #8) residents in the Stage

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Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING 125023 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 628 7TH STREET LANAI COMMUNITY HOSPITAL LANAI CITY, HI 96763 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 4 173 Continued From page 2 4 173 WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS 2 sample. FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 2/24/2017 an Inter-Disciplinary Team meeting with was held and Findings include: the care plan for resident #6 was discussed and 3/6/17 1) On 02/10/2017 at 8:10 AM medical record thereafter modified on 3/6/2017 to include the care review was conducted. It was found that on plan for the use of Zoloft, including indication and 06/23/16 Res #6 has a written physician's order considerations for providing the care of the resident. At the same meeting, the care plan for resident #8 for Zoloft 50 mg daily. The care plan was was reviewed / modified and orders obtained on reviewed. There was no care plan for the use of 3/6/17 3/6/2017 to perform an electrolyte laboratory test Zoloft. Staff member #1 (SM#1) was interviewed every six months instead of "more frequently." The 2/18/17 and asked if there was a care plan for Zoloft and test was last done on 2/18/2017 and recurring orders were also obtained for repeating this test 3/6/2017. 3/6/17 its use in Res #6's medical record and she stated The last A1C test was completed last on 2/23/16 and "it is not in the care plan". SM#8 was interviewed to be repeated on 3/8/2017 and every 6 months 2/23/17 and stated Zoloft is used to treat Res #6's palsy thereafter. The care plan was revised to reflect the 3/8/17 due dates of the upcoming tests in order to assure disorder and not for depression. that orders are obtained in sufficient time. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE 2) On 02/10/2017 at 8:27 AM during a medical AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE record review it was noted that Res #8 was TAKEN: All residents were at risk of being affected receiving Lasix 20 po mg Q daily. The care plan by the deficient practice of not having a current and was updated on 11/30/15 at 23:47 to include adequate comprehensive person-centered care plan. All of the residents at Lanai Community Hospital had Lasix 20 mg Q daily for history of Congestive 2/24/17 their care plans reviewed and revised at the Heart Failure (CHF), Chronic Kidney Disease Inter-Disciplinary Team meeting on 2/24/2017 (CKD) and cardiomyopathy. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE On 02/23/16 at 11:32 there were added WILL NOT RECUR: Staff training of our Long-Term interventions to the care plan to include Care Coordinator and Director of Nursing / Assistant "Plan-Assess/Monitor Lab Values check A1C Director of Nursing on the modification of resident 3/6/17 care plans within our electronic medical record every 6 months, check hemogram and CMP charting system was completed by a Maui Region yearly, will monitor electrolytes more frequently Clinical Informatacist on 3/6/2017. Handouts on this since on Lasix." training will be shared with other licensed staff and 3/10/17 their education completed by 3/10/2017 It is the expectation that all licensed staff will review and Further review of the electronic and hard copy update the care plan of the residents through the medical records revealed that there was only one course of each shift. A comprehensive review with electrolyte check done. It was done on 02/23/16, revisions of all resident care plans will occur on no 3/31/17 in which the electrolytes were within normal less than a monthly basis by the Long-Term Care Coordinator. Future actions will also be noted in the range. SM#1 was interviewed and asked if she care plan. The need for physician orders will be could pull up any copies of electrolyte test results determined and orders obtained to meet the goals from the resident's electronic medical record or if set forth in the care plans. The LTC Coordinator will share modifications with staff, including the Director she could find any other results in Res #8's hard of Nursing / Assistant Administrator as needed. copy medical record. The only results that she

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION i:	(X3) DATE COMF	SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
4 173	Therefore the interv was not implemented In summary, the fact	veyor was from 02/23/16. rention written in the care planed. sility failed to develop and ehensive person-centered	4 173	HOW THE CORRECTIVE ACTIVE ACTIVE ACTIVE WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECU Acknowledgement of care play reviews, including orders obwill be shared at the quality assurance committee and at scheduled IDT meetings.	JR: an	4/12/17
	(c) The overall plan periodically by the indetermine if goals changes are require and as necessitated condition. This Statute is not resident and not revise and in 6 (Resident #5) resident family member #3 (Findings include: During an interview of family member #3 (Findings include: Durings include: Durin	isciplinary care process of care shall be reviewed aterdisciplinary team to have been met, if any d to the overall plan of care, d by changes in the resident's end record review, the facility applement a care plan for 1 of dents reviewed in Stage 1. on 2/9/17 at 9:02 A.M. with FM#3) who stated "as far as I wondered if she would get by. I also inquired about a amogram during the IDT and a to me". P.M. inquiry with SM#1 and view regarding Resident #5	4 175	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDEN FOUND TO HAVE BEEN AFFECTED BY DEFICIENT PRACTICE: A meeting was hearth 1, 2017 with the family member of F#5, nursing, and the Resident's physician. Progress and goals with physical therapy of discussed. The decision was made to purtesting alternative to a colonoscopy. The soccult blood was ordered 3/7/2017 and the will be shared with the physician to include discussion with the resident's family member pap smear was included in the care plan a conducted at the Lanai Cancer Screening summer 2017. The resident does not wish leave the island for additional testing at this The issue of mammogram testing was clar determined to be not relevant. HOW THE FACILITY WILL IDENTIFY OT RESIDENTS HAVING THE POTENTIAL TAFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACT WILL BE TAKEN: All residents were at risbeing affected by the deficient practice of rhaving adequate participation in the reside comprehensive person-centered care plan the residents at Lanai Community Hospital their care plans reviewed and revised at the Inter-Disciplinary Team meeting on February and the state of the comprehensive person-centered care plan the residents at Lanai Community Hospital their care plans reviewed and revised at the Inter-Disciplinary Team meeting on February and the care plans reviewed and revised at the Inter-Disciplinary Team meeting on February and the care plans reviewed and revised at the Inter-Disciplinary Team meeting on February and the care plans reviewed and revised at the Inter-Disciplinary Team meeting on February and the care plans reviewed and revised at the Inter-Disciplinary Team meeting on February and the care plans reviewed and revised at the Inter-Disciplinary Team meeting on February and the care plans reviewed and revised at the Inter-Disciplinary Team meeting on February and the care plans reviewed and revised at the Inter-Disciplinary Team meeting on February and the care plans reviewed and revised at the Inter-Disciplinary Team meet	THE neld on Resident were sue a stool for e results e in per. The neld to be in early not stime. Fified and HER TO BE CTION sk of not not sk of had e	3/1/17 3/7/17 7/2017

Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 125023 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **628 7TH STREET** LANAI COMMUNITY HOSPITAL LANAI CITY, HI 96763 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) WHAT MEASURES WILL BE PUT INTO PLACE OR 4 175 | Continued From page 4 4 175 WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL (Res#5). Notes reviewed for Interdisciplinary NOT RECUR: Staff training of our Long-Term Care team (IDT) quarterly meeting. A note was Coordinator and Director of Nursing / Assistant Director entered by the RAI coordinator dated 7/1/16 of Nursing on the modification of resident care plans 3/6/17 about the follow-up of a colonoscopy and a within our electronic medical record charting system was completed by a Maui Region Clinical mammogram as requested by her daughter in Informatacists on 3/6/2017. Handouts on this training which SM#13 agreed with. will be shared with other licensed staff and their 3/10/17 education completed by 3/10/2017 It is the expectation that all licensed staff will review and update the care On 02/10/2017 at 9:34 A.M. SM#1 stated that plan of the residents through the course of each shift. they did not implement follow-up for the A comprehensive review with revisions of all resident mammogram and colonoscopy as had been 3/31/17 care plans will occur on no less than a monthly basis by discussed in their IDT quarterly meeting. SM#1 the Long-Term Care Coordinator. Future actions will also be noted in the care plan. The need for physician would follow-up with SM#13. SM#1 further stated orders will be determined and orders obtained to meet that SM#14 stated to her that because they could 7/2017 the goals set forth in the care plans. The LTC not do the mammogram or colonoscopy on Coordinator will share modifications with staff, including facility, she did not follow-up with this. the Director of Nursing / Assistant Administrator as needed. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT In summary, the facility failed to revise and PRACTICE WILL NOT RECUR: Acknowledgement of 4/12/17 implement a careplan for 1 of 6 residents care plan reviews, including family requests and orders obtained will be shared at the quality assurance reviewed in Stage I of the survey. committee and at scheduled IDT meetings. 4 176 1-94.1-43(d) Interdisciplinary care process 4 176 WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT (d) Implementation of the overall plan of care 3/1/17 PRACTICE: A meeting was held on March 1, 2017with shall be documented in each resident's medical the family member of Resident #5, nursing, and the record. Resident's physician. Progress and goals with physical therapy were discussed. The decision was made to pursue a testing alternative to a colonoscopy. The stool 3/7/17 This Statute is not met as evidenced by: for occult blood was ordered 3/7/2017 and the results will Based on interview and record review, the facility be shared with the physician to include in discussion with the resident's family member. The pap smear was did not revise and implement a care plan for 1 of included in the care plan and to be conducted at the Lanai 7/2017 6 (Resident #5) residents reviewed in Stage 1. Cancer Screening in early summer 2017. The resident does not wish to leave the island for additional testing at this time. The issue of mammogram testing was clarified Findings include: and determined to be not relevant. During an interview on 2/9/17 at 9:02 A.M. with HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE family member #3 (FM#3) who stated "as far as AFFECTED BY THE SAME DEFICIENT PRACTICE AND her physical therapy, I wondered if she would get WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents were at risk of being affected by the deficient more physical therapy. I also inquired about a practice of not having adequate participation in the pap smear and mammogram during the IDT and resident's comprehensive person-centered care plan. All 2/24/17 they did not get back to me". of the residents at Lanai Community Hospital had their

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care plans reviewed and revised at the Inter-Disciplinary

Team meeting on February 24, 2017.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE	SURVEY	
			A. BUILDING	:			
		125023	B. WING		02/1	0/2017	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
LANAI C	LANAI COMMUNITY HOSPITAL 628 7TH STREET LANAI CITY, HI 96763						
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4 176	concurrent record re (Res#5). Notes reviteam (IDT) quarterly entered by the RAI about the follow-up mammogram as recombined which SM#13 agree On 02/10/2017 at 9: they did not implement mammogram and concurrent in their ID would follow-up with that SM#14 stated to not do the mammogram facility, she did not follow-up the summary, the factories in the summary, the factories is not the summary, the factories is not summary.	P.M. inquiry with SM#1 and eview regarding Resident #5 ewed for Interdisciplinary meeting. A note was coordinator dated 7/1/16 of a colonoscopy and a quested by her daughter in d with. 34 A.M. SM#1 stated that ent follow-up for the colonoscopy as had been of quarterly meeting. SM#1 SM#13. SM#1 further stated to her that because they could tram or colonoscopy on collow-up with this.	4 176	WHAT MEASURES WILL BE PUT INTO PLA WHAT SYSTEMIC CHANGES YOU WILL MENSURE THAT THE DEFICIENT PRACTICE NOT RECUR: Staff training of our Long-Ter Coordinator and Director of Nursing / Assista of Nursing on the modification of resident car within our electronic medical record charting was completed by a Maui Region Clinical Informatacists on 3/6/2017. Handouts on this will be shared with other licensed staff and the education completed by 3/10/2017 It is the exthat all licensed staff will review and update the plan of the residents through the course of ea A comprehensive review with revisions of all care plans will occur on no less than a month by the Long-Term Care Coordinator. Future will also be noted in the care plan. The need physician orders will be determined and order obtained to meet the goals set forth in the car The LTC Coordinator will share modifications including the Director of Nursing / Assistant Administrator as needed. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Acknowledg care plan reviews, including family requests a obtained will be shared at the quality assurant committee and at scheduled IDT meetings.	AKE TO WILL IN Care In	3/6/17 3/10/17 3/31/17 4/12/17	
	arrangement with provide consultation for ordering, stor and recordkeeping oprovisions for emer	Il employ a licensed have a written contractual a licensed pharmacist, to on methods and procedures ing, administering, disposing, of drugs and biologicals, and regency service. The tas evidenced by: iew and staff interview the rately discontinue a 1 of 6 (Resident #4)	4 184	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDEN' FOUND TO HAVE BEEN AFFECTED BY TO DEFICIENT PRACTICE: The physician of #4 was notified of the medication error on 2/10/2017 and a clarification order was obtain event report was completed on 2/10/20 nursing staff and submitted to the Director Nursing / Assistant Administrator, who in tucontacted the Administrator that same day. THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTIVE AND WHAT CORRECTIVE ACTIVE AND WHAT CORRECTIVE OF IN having adequate measures in place to assist they receive medications appropriately as a review for accuracy of all ordered medical against the medication administration recorresidents was completed on 2/24/2017.	THE Resident ained. 17 by the of rn HOW DBE TION sk of ot ure that ordered. tions	2/10/17 2/10/17 2/24/17	

PRINTED: 02/21/2017 FORM APPROVED Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ 125023 B. WING 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **628 7TH STREET** LANAI COMMUNITY HOSPITAL LANAI CITY, HI 96763 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) WHAT MEASURES WILL BE PUT INTO PLACE OR 4 184 Continued From page 6 4 184 WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL On the afternoon of 02/09/2017 Resident #4's NOT RECUR: The correct process for discontinuing (Res #4) medical record was reviewed. During medications was reviewed with staff and begun on 2/24/17 medical record review, there was a physician's 2/24/2017 and is expected to be completed by order written on 1/21/17 to "DC Bactrim DS". The 3/10/17 3/10/2017 - this includes 1) the requirement for each staff to review new physician orders from the prior Medication Administration Record (MAR) was sheet to validate the proper transcription of physician reviewed and revealed that the medication was orders, 2) the modification of the current medication D/C'd on 1/22/17. However, the February 2017 administration record, and 3) the requirement for review / modification for accuracy and signature of staff MAR showed that the resident was still receiving prior to initiating a pre-printed medication administration Bactrim DS daily at 0630 AM from 02/01/17 record from the remote pharmacy. The Long-Term 02/09/17 in which the resident received 9 extra Care Coordinator will review include an extra review doses of Bactrim DS, SM#3 was interviewed and medication administration records at the beginning of 4/7/17 each month to assure accuracy / make necessary shown the January and February 2017 MARs and corrections and complete event reports as needed. doctor's orders and he stated "That's an error." Results of these audits will be shared in real-time with Then he phoned the doctor and received an the Director of Nursing / Assistant Administrator for order, "To restart Bactrim DS 1 po daily on appropriate action. HOW THE CORRECTIVE ACTION WILL BE 02/09/17 at 1349". MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The Long-Term Care 4/12/17 In summary, the facility failed to follow doctor's Coordinator will report the results of the audits at quality assurance meetings and the Director of Nursing / written order to discontinue Bactrim DS for Res Assistant Administrator will report on event reports and #4. actions taken. 4 193 11-94.1-46(j) Pharmaceutical services 4 193 WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE (i) Medication errors and drug reactions shall be DEFICIENT PRACTICE: The physician of recorded in the resident's chart and reported Resident #4 was notified of the medication error on 2/10/17 immediately to the physician, physician 2/10/2017 and a clarification order was obtained. assistant, or APRN who ordered the drug, and a An event report was completed on 2/10/2017 by the nursing staff and submitted to the Director of medication error report shall be prepared and Nursing / Assistant Administrator, who in turn given to the administrator of the facility or director contacted the Administrator that same day. of nursing for review and appropriate action, HOW THE FACILITY WILL IDENTIFY OTHER according to facility policy. RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents were at risk of This Statute is not met as evidenced by: being affected by the deficient practice of not Based on record review and staff interview the having adequate measures in place to assure that

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facility failed to accurately discontinue a

physician's order for 1 of 6 (Resident #4)

residents in the Stage 2 sample list.

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residents was completed on 2/24/2017.

they receive medications appropriately as ordered.

A review for accuracy of all ordered medications against the medication administration records for 2/24/17

Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING_ 125023 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **628 7TH STREET** LANAI COMMUNITY HOSPITAL LANAI CITY, HI 96763 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) WHAT MEASURES WILL BE PUT INTO PLACE OR 4 193 Continued From page 7 4 193 WHAT SYSTEMIC CHANGES YOU WILL MAKE TO Findings include: ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The correct process for discontinuing 2/24/17 On the afternoon of 02/09/2017 Resident #4's medications was reviewed with staff and begun on (Res #4) medical record was reviewed. During 2/24/2017 and is expected to be completed by 3/10/17 medical record review, there was a physician's 3/10/2017 - this includes 1) the requirement for each staff to review new physician orders from the prior order written on 1/21/17 to "DC Bactrim DS". The sheet to validate the proper transcription of physician Medication Administration Record (MAR) was orders, 2) the modification of the current medication reviewed and revealed that the medication was administration record, and 3) the requirement for review / modification for accuracy and signature of staff D/C'd on 1/22/17. However, the February 2017 prior to initiating a pre-printed medication MAR showed that the resident was still receiving administration record from the remote pharmacy. The Bactrim DS daily at 0630 AM from 02/01/17 -Long-Term Care Coordinator will review include an 02/09/17 in which the resident received 9 extra extra review medication administration records at the 4/7/17 doses of Bactrim DS. SM#3 was interviewed and beginning of each month to assure accuracy / make necessary corrections and complete event reports as shown the January and February 2017 MARs and needed. Results of these audits will be shared in doctor's orders and he stated "That's an error." real-time with the Director of Nursing / Assistant Then he phoned the doctor and received an Administrator for appropriate action. HOW THE CORRECTIVE ACTION WILL BE order, "To restart Bactrim DS 1 po daily on MONITORED TO ENSURE THE DEFICIENT 02/09/17 at 1349". PRACTICE WILL NOT RECUR: The Long-Term 4/12/17 Care Coordinator will report the results of the audits at quality assurance meetings and the Director of In summary, the facility failed to follow doctor's Nursing / Assistant Administrator will report on event written order to discontinue Bactrim DS for Res reports and actions taken. #4. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED 4 214 11-94.1-55(a) Housekeeping 4 2 1 4 FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The kitchen 2/23/17 basin and hand-washing sinks were re-caulked and cleaned (a) Each facility shall have a plan for routine on 2/23/2017. Neither of the sinks leak or are in danger of periodic cleaning of the entire building and failure. The temperature of the food storage area has been monitored and a literature search conducted to review premises. standards for food storage and it has been determined that there is no valid need for concern about the location. The shower chair noted for resident #4, as described was taken out of use on 2/10/2017 and it was properly disposed. The 2/10/17 remaining shower chairs were assessed and not found to This Statute is not met as evidenced by: have rust or other signs of maintenance needs. No additional shower chairs were determined to be needed at this time. Based on interview and observation, the facility failed to maintain equipment in safe operating HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE condition. SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents were at risk of 1) On 2/10/17 during kitchen tour, it was noted being affected by the deficient practice of not assuring that 3/7/17 essential equipment is in safe operating conditions. A review that the main basin that dishes are washed had of the facility equipment operation was completed on rust along the perimeter of sink and leaks. 3/7/2017 and appropriate actions for correction were taken. Interview with SM#4 stated that a request was

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Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING _ 125023 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 628 7TH STREET LANAI COMMUNITY HOSPITAL LANAI CITY, HI 96763 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 4 214 Continued From page 8 4 2 1 4 WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC submitted to have the sink recaulked on 2/4/17. CHANGES YOU WILL MAKE TO SM#4 verbalized that their was also concern that ENSURE THAT THE DEFICIENT when filling sink with water that the sink may PRACTICE WILL NOT RECUR: A collapse because of the rust. It was also observed that the handwashing sink was leaking weekly walk-through of the facility with under sink seal areas. an audit tool will be completed by the maintenance staff and items identified On further interview, SM#4 stated that storage 3/7/17 will be noted and corrective actions area maintained with a manual fan for correct taken / documented. Started on March temperature because it will get too hot for food 7, 2017 to be completed weekly. Staffs 2/14/17 storage. SM#4 stated the concern that the fan is were re-educated on 2/14/2017 to not working correctly and if it breaks, promptly notify maintenance staff of termperature will become too hot for food issues or concerns that they identify to storage. On 2/10/17 at 10:00, discussed these assure that they are promptly observations with SM#1 who stated that she addressed. The results of the weekly would look into these concerns. walk-through of the facility audit will be 3/7/17 shared in real-time with the Director of 2) On 2/9/17 during an interview with Resident #4 (Res #4) surveyor noticed the shower chair in Nursing / Assistant Administrator, along resident's shower stall that had rust on it. All four with the actions taken or planned to metal legs had rust up to the area that meets the resolve issues. The Administrator will seat. On the morning of 2/10/17 SM #3 was be contacted to assist as necessary to interviewed and asked if the shower chair in Res assure that there are adequate #4's room is currently being used for the resident resources to address issues identified. and he acknowledged that is was. SM #3 stated HOW THE CORRECTIVE ACTION that new shower chairs had been purchased and WILL BE MONITORED TO ENSURE needed to be switched out. Staff member #1 was THE DEFICIENT PRACTICE WILL interviewed about replacement shower chairs and NOT RECUR: Summaries of the 4/12/17 she acknowledged that new shower chairs had audits and actions taken will be a point been purchased. of discussion at the quality assurance In summary, the facility failed to maintain meetina. equipments for resident care in a safe operating condition. 4 218 11-94.1-55(e) Housekeeping 4 218 (e) All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair.

Hawaii Dept. of Health, Office of Health Care Assuranc STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	i:	COM	CETED	
		125023	B. WING		02/1	0/2017	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
	628 7TH STREET						
LANAIC	LANAI COMMUNITY HOSPITAL LANAI CITY, HI 96763						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)	D BE	(X5) COMPLETE DATE	
4 218	Based on interview failed to maintain ed condition. 1) On 2/10/17 during that the main basin rust along the perim Interview with SM#4 submitted to have the SM#4 verbalized that	met as evidenced by: and observation, the facility quipment in safe operating g kitchen tour, it was noted that dishes are washed had leter of sink and leaks. I stated that a request was he sink recaulked on 2/4/17. at their was also concern that h water that the sink may	4 218	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENT FOUND TO HAVE BEEN AFFECTED BY TO EFICIENT PRACTICE: The kitchen basin hand-washing sinks were re-caulked and cl 2/23/2017. Neither of the sinks leak or are of failure. The temperature of the food stors has been monitored and a literature search conducted to review standards for food stors has been determined that there is no valid in concern about the location. The shower ch for resident #4, as described was taken out 2/10/2017 and it was properly disposed. The remaining shower chairs were assessed an found to have rust or other signs of mainten needs. No additional shower chairs were do to be needed at this time. HOW THE FACILITY WILL IDENTIFY OTH RESIDENTS HAVING THE POTENTIAL TO	Was and eaned on in danger age area age and it leed for air noted of use on leed not eatermined ER	2/23/17	
	collapse because of observed that the haunder sink seal area. On further interview area maintained with temperature becaus storage. SM#4 state not working correctly termperature will be storage. On 2/10/17	the rust. It was also andwashing sink was leaking as. , SM#4 stated that storage h a manual fan for correct se it will get too hot for food ed the concern that the fan is		AFFECTED BY THE SAME DEFICIENT PER AND WHAT CORRECTIVE ACTION WILL ITAKEN: All residents were at risk of being by the deficient practice of not assuring that equipment is in safe operating conditions. A of the facility equipment operation was communicated and appropriate actions for correct taken. WHAT MEASURES WILL BE PUT INTO PLICHMAT SYSTEMIC CHANGES YOU WILL MENSURE THAT THE DEFICIENT PRACTIONOT RECUR: A weekly walk-through of the with an audit tool will be completed by the maintenance staff and items identified will be and corrective actions taken / documented.	ACTICE BE affected essential A review bleted on ion were ACE OR MAKE TO EWILL he facility e noted Started	3/7/17 3/7/17	
	would look into these 2) On 2/9/17 during (Res #4) surveyor not resident's shower stametal legs had rust a seat. On the morning interviewed and ask #4's room is currently and he acknowledge that new shower channeded to be switch.	an interview with Resident #4 oticed the shower chair in all that had rust on it. All four up to the area that meets the g of 2/10/17 SM #3 was ed if the shower chair in Res ly being used for the resident ed that is was. SM #3 stated airs had been purchased and ed out. Staff member #1 was		on 3/7/2017 to be completed weekly. Staffs re-educated on 2/14/2017 to promptly notify maintenance staff of issues or concerns that identify to assure that they are promptly add. The results of the weekly walk-through of the audit will be shared in real-time with the Dire Nursing / Assistant Administrator, along with actions taken or planned to resolve issues. Administrator will be contacted to assist as to assure that there are adequate resources address issues identified. HOW THE CORRECTIVE ACTION WILL BIMONITORED TO ENSURE THE DEFICIEN PRACTICE WILL NOT RECUR: Summarie audits and actions taken will be a point of displacements.	they ressed. e facility ector of the The necessary to T	2/14/17 3/7/17 4/12/17	
		placement shower chairs and		at the quality assurance meeting.			

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FORM APPROVED Hawaii Dept. of Health, Office of Health Care Assurance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: _ B. WING _ 125023 02/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 628 7TH STREET LANAI COMMUNITY HOSPITAL LANAI CITY, HI 96763 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) 4 218 Continued From page 10 4 218 WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS been purchased. FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The fans in the 2/10/17 In summary, the facility failed to maintain kitchen were cleaned on 2/10/2017. Staff was re-educated to notify the Director or Nursing / equipments for resident care in a safe operating Assistant Administrator of maintenance needs if condition. they are not promptly addressed. HOW THE FACILITY WILL IDENTIFY OTHER 4 243 11-94.1-64(a) Engineering and maintenance 4 243 RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE (a) The facility shall maintain all essential ACTION WILL BE TAKEN: All residents were mechanical, electrical, and resident care at risk of being affected by the deficient practice equipment in safe operating condition. of not assuring a functional, sanitary, and 3/7/17 comfortable environment for staff, residents, This Statute is not met as evidenced by: and the public. A review of the facility Based on interview and observation, the facility equipment operation was completed on failed to provide a sanitary environment for 3/7/2017 and appropriate actions for correction residents, staff and public. were taken. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES On 2/08/17 at 0900 A.M. during an initial kitchen YOU WILL MAKE TO ENSURE THAT THE tour, it was noted that two fans above the DEFICIENT PRACTICE WILL NOT RECUR: dishwashing sinks were prominent with dust and A weekly walk-through of the facility with an 3/7/17 needed to be cleaned. SM#4 stated that they audit tool will be completed by the maintenance have not been cleaned on a regular basis and did staff and items identified will be noted and not have a service log. corrective actions taken / documented. Staffs 2/14/17 were re-educated on 2/14/2017 to promptly On 2/10/17 at 0830 A.M. during a follow-up notify maintenance staff of issues or concerns that they identify to assure that they are kitchen tour, it was noted that the two fans above promptly addressed. The results of the weekly the dishwashing sinks were still covered with walk-through of the facility audit will be shared dust. SM#4 stated that a request was sent for the 3/7/17 in real-time with the Director of Nursing / fans to be cleaned. Assistant Administrator, along with the actions taken or planned to resolve issues. The On 2/10/17 at 10:00, discussed these Administrator will be contacted to assist as observations with SM#1 who stated that she necessary to assure that there are adequate would look into these concerns and that resources to address issues identified. HOW housekeeping takes care of this. THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT 4/12/17 In summary, the facility failed to provide a clean PRACTICE WILL NOT RECUR: Summaries of

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residents.

and sanitary environment for their staff and

the audits and actions taken will be a point of

discussion at the quality assurance meeting.

Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

125023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING:

COMPLETED

02/10/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

628 7TH STREET

LANAI CITY, HI 96763

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)

LANAI C	OMMUNITY HOSPITAL 628 7TH S	STREET TY, HI 9676	63	
(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
4 244 4 244	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The fans in the kitchen were cleaned on 2/102017. Staff was re-educated to notify the Director or Nursing / Assistant Administrator of maintenance needs if they are not promptly addressed. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents were at risk of being affected by the deficient practice of not assuring a written preventative maintenance program to assure a functional, sanitary, and comfortable environment for staff, residents, and the public. A review of the facility equipment operation was completed on 3/7/2017 and appropriate actions for correction were taken. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: A weekly walk-through of the facility with an audit tool will be completed by the maintenance staff and items identified will be noted and corrective actions taken / documented. Staffs were re-educated on 2/14/2017 to promptly notify maintenance staff of issues or concerns that they identify to assure that they are promptly addressed. A written preventative maintenance program to assure a functional, sanitary, and comfortable environment for staff, residents, and the public was completed on 3/10/2017. Staff education on this new process will be completed by 3/24/2017. The results of the weekly walk-through of the facility audit will be shared in real-time with the Director	COMPLETE
			of Nursing / Assistant Administrator, along with the actions taken or planned to resolve issues. The Administrator will be contacted to assist as necessary to assure that there are adequate resources to address issues identified. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Summaries of the audits and actions taken will be a point of discussion at the quality assurance meeting.	4/12/17

Office of Health Care Assurance