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
	125023	A. BUILDING: _____ B. WING _____	02/10/2017

RECEIVED
2017 MAR 15 A 11:21
STATE OF HAWAII
DEPT. OF HEALTH

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANAI COMMUNITY HOSPITAL	628 7TH STREET LANAI CITY, HI 96763

(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
4 000	11-94.1 Initial Comments A state re-lincensing survey was conducted at this facility from 02/08/17 to 02/10/17. At the time of entrance, the census included 7 residents.	4 000	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The physician of Resident #4 was notified of the medication error on 2/10/2017 and a clarification order was obtained. An event report was completed on 2/10/2017 by the nursing staff and submitted to the Director of Nursing / Assistant Administrator, who in turn contacted the Administrator that same day.	2/10/17
4 152	11-94.1-39(e) Nursing services (e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures. The policies and procedures shall include but not be limited to: (1) Written procedures for personnel to follow in an emergency including: (A) Care of the resident; (B) Notification of the attending physician and other persons responsible for the resident; and (C) Arrangements for transportation, hospitalization, or other appropriate services; (2) All treatment and care provided relative to the resident's needs and requirements for documentation; and (3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized This Statute is not met as evidenced by: Based on record review and staff interview the facility failed to accurately discontinue a	4 152	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 having adequate measures in place to assure that they receive medications appropriately as ordered. A review for accuracy of all ordered medications against the medication administration records for residents was completed on 2/24/2017. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The correct process for discontinuing medications was reviewed with staff and begun on 2/24/2017 and is expected to be completed by 3/10/2017 – this includes 1) the requirement for each staff to review new physician orders from the prior sheet to validate the proper transcription of physician orders, 2) the modification of the current medication administration record, and 3) the requirement for review / modification for accuracy and signature of staff prior to initiating a pre-printed medication administration record from the remote pharmacy. The Long-Term Care Coordinator review will include an extra review medication administration records at the beginning of each month to assure accuracy / make necessary corrections and complete event reports as needed. Results of these audits will be shared in real-time with the Director of Nursing / Assistant Administrator for appropriate action. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The Long-Term Care Coordinator will report the results of the audits at quality assurance meetings and the Director of Nursing / Assistant Administrator will report on event reports and actions taken.	2/24/17 2/24/17 3/10/17 4/7/17 4/12/17

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Paul Boyton — Interim Administrator — 3/07/2017

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4 152	Continued From page 1 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.	4 152		
4 173	11-94.1-43(a) Interdisciplinary care process (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	4 173		

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4 173	Continued From page 2 2 sample. Findings include: 1) On 02/10/2017 at 8:10 AM medical record review was conducted. It was found that on 06/23/16 Res #6 has a written physician's order for Zoloft 50 mg daily. The care plan was reviewed. There was no care plan for the use of Zoloft. Staff member #1 (SM#1) was interviewed and asked if there was a care plan for Zoloft and its use in Res #6's medical record and she stated "it is not in the care plan". SM#8 was interviewed and stated Zoloft is used to treat Res #6's palsy disorder and not for depression. 2) On 02/10/2017 at 8:27 AM during a medical record review it was noted that Res #8 was receiving Lasix 20 po mg Q daily. The care plan was updated on 11/30/15 at 23:47 to include Lasix 20 mg Q daily for history of Congestive Heart Failure (CHF), Chronic Kidney Disease (CKD) and cardiomyopathy. On 02/23/16 at 11:32 there were added interventions to the care plan to include "Plan-Assess/Monitor Lab Values check A1C every 6 months, check hemogram and CMP yearly, will monitor electrolytes more frequently since on Lasix." Further review of the electronic and hard copy medical records revealed that there was only one electrolyte check done. It was done on 02/23/16, in which the electrolytes were within normal range. SM#1 was interviewed and asked if she could pull up any copies of electrolyte test results from the resident's electronic medical record or if she could find any other results in Res #8's hard copy medical record. The only results that she	4 173	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 2/24/2017 an Inter-Disciplinary Team meeting with was held and the care plan for resident #6 was discussed and thereafter modified on 3/6/2017 to include the care plan for the use of Zoloft, including indication and considerations for providing the care of the resident. At the same meeting, the care plan for resident #8 was reviewed / modified and orders obtained on 3/6/2017 to perform an electrolyte laboratory test every six months instead of "more frequently." The test was last done on 2/18/2017 and recurring orders were also obtained for repeating this test 3/6/2017. The last A1C test was completed last on 2/23/16 and to be repeated on 3/8/2017 and every 6 months thereafter. The care plan was revised to reflect the due dates of the upcoming tests in order to assure that orders are obtained in sufficient time. 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 having a current and adequate comprehensive person-centered care plan. All of the residents at Lanai Community Hospital had their care plans reviewed and revised at the Inter-Disciplinary Team meeting on 2/24/2017 WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Staff training of our Long-Term Care Coordinator and Director of Nursing / Assistant Director of Nursing on the modification of resident care plans within our electronic medical record charting system was completed by a Maui Region Clinical Informatacist on 3/6/2017. Handouts on this training will be shared with other licensed staff and their education completed by 3/10/2017 It is the expectation that all licensed staff will review and update the care plan of the residents through the course of each shift. A comprehensive review with revisions of all resident care plans will occur on no less than a monthly basis by the Long-Term Care Coordinator. Future actions will also be noted in the care plan. The need for physician orders will be determined and orders obtained to meet the goals set forth in the care plans. The LTC Coordinator will share modifications with staff, including the Director of Nursing / Assistant Administrator as needed.	3/6/17 3/6/17 2/18/17 3/6/17 2/23/17 3/8/17 2/24/17 3/6/17 3/10/17 3/31/17

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4 173	Continued From page 3 could show the surveyor was from 02/23/16. Therefore the intervention written in the care plan was not implemented. In summary, the facility failed to develop and implement a comprehensive person-centered care plan for residents #6 and #8.	4 173	HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Acknowledgement of care plan reviews, including orders obtained will be shared at the quality assurance committee and at scheduled IDT meetings.	4/12/17
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on interview and record review, the facility did not revise and implement a care plan for 1 of 6 (Resident #5) residents reviewed in Stage 1. Findings include: During an interview on 2/9/17 at 9:02 A.M. with family member #3 (FM#3) who stated "as far as her physical therapy, I wondered if she would get more physical therapy. I also inquired about a pap smear and mammogram during the IDT and they did not get back to me". 02/09/2017 at 1:51 P.M. inquiry with SM#1 and concurrent record review regarding Resident #5	4 175	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A meeting was held on March 1, 2017 with the family member of Resident #5, nursing, and the 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 for occult blood was ordered 3/7/2017 and the results will be shared with the physician to include in discussion with the resident's family member. The pap smear was included in the care plan and to be conducted at the Lanai 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 and determined to be not relevant. 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 having adequate participation in the resident's comprehensive person-centered care plan. All of the residents at Lanai Community Hospital had their care plans reviewed and revised at the Inter-Disciplinary Team meeting on February 24, 2017.	3/1/17 3/7/17 7/2017 2/24/17

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4 175	Continued From page 4 (Res#5). Notes reviewed for Interdisciplinary team (IDT) quarterly meeting. A note was entered by the RAI coordinator dated 7/1/16 about the follow-up of a colonoscopy and a mammogram as requested by her daughter in which SM#13 agreed with. On 02/10/2017 at 9:34 A.M. SM#1 stated that they did not implement follow-up for the mammogram and colonoscopy as had been discussed in their IDT quarterly meeting. SM#1 would follow-up with SM#13. SM#1 further stated that SM#14 stated to her that because they could not do the mammogram or colonoscopy on facility, she did not follow-up with this. In summary, the facility failed to revise and implement a careplan for 1 of 6 residents reviewed in Stage I of the survey.	4 175	WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Staff training of our Long-Term Care Coordinator and Director of Nursing / Assistant Director of Nursing on the modification of resident care plans within our electronic medical record charting system was completed by a Maui Region Clinical Informatacists on 3/6/2017. Handouts on this training will be shared with other licensed staff and their education completed by 3/10/2017 It is the expectation that all licensed staff will review and update the care plan of the residents through the course of each shift. A comprehensive review with revisions of all resident care plans will occur on no less than a monthly basis by the Long-Term Care Coordinator. Future actions will also be noted in the care plan. The need for physician orders will be determined and orders obtained to meet the goals set forth in the care plans. The LTC Coordinator will share modifications with staff, including the Director of Nursing / Assistant Administrator as needed. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Acknowledgement of care plan reviews, including family requests and orders obtained will be shared at the quality assurance committee and at scheduled IDT meetings.	3/6/17 3/10/17 3/31/17 7/2017 4/12/17
4 176	1-94.1-43(d) Interdisciplinary care process (d) Implementation of the overall plan of care shall be documented in each resident's medical record. This Statute is not met as evidenced by: Based on interview and record review, the facility did not revise and implement a care plan for 1 of 6 (Resident #5) residents reviewed in Stage 1. Findings include: During an interview on 2/9/17 at 9:02 A.M. with family member #3 (FM#3) who stated "as far as her physical therapy, I wondered if she would get more physical therapy. I also inquired about a pap smear and mammogram during the IDT and they did not get back to me".	4 176	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A meeting was held on March 1, 2017with the family member of Resident #5, nursing, and the 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 for occult blood was ordered 3/7/2017 and the results will be shared with the physician to include in discussion with the resident's family member. The pap smear was included in the care plan and to be conducted at the Lanai 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 and determined to be not relevant. 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 having adequate participation in the resident's comprehensive person-centered care plan. All of the residents at Lanai Community Hospital had their care plans reviewed and revised at the Inter-Disciplinary Team meeting on February 24, 2017.	3/1/17 3/7/17 7/2017 2/24/17

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4 176	Continued From page 5 02/09/2017 at 1:51 P.M. inquiry with SM#1 and concurrent record review regarding Resident #5 (Res#5). Notes reviewed for Interdisciplinary team (IDT) quarterly meeting. A note was entered by the RAI coordinator dated 7/1/16 about the follow-up of a colonoscopy and a mammogram as requested by her daughter in which SM#13 agreed with. On 02/10/2017 at 9:34 A.M. SM#1 stated that they did not implement follow-up for the mammogram and colonoscopy as had been discussed in their IDT quarterly meeting. SM#1 would follow-up with SM#13. SM#1 further stated that SM#14 stated to her that because they could not do the mammogram or colonoscopy on facility, she did not follow-up with this. In summary, the facility failed to revise and implement a careplan for 1 of 6 residents reviewed in Stage I of the survey	4 176	WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Staff training of our Long-Term Care Coordinator and Director of Nursing / Assistant Director of Nursing on the modification of resident care plans within our electronic medical record charting system was completed by a Maui Region Clinical Informatacists on 3/6/2017. Handouts on this training will be shared with other licensed staff and their education completed by 3/10/2017 It is the expectation that all licensed staff will review and update the care plan of the residents through the course of each shift. A comprehensive review with revisions of all resident care plans will occur on no less than a monthly basis by the Long-Term Care Coordinator. Future actions will also be noted in the care plan. The need for physician orders will be determined and orders obtained to meet the goals set forth in the care plans. The LTC Coordinator will share modifications with staff, including the Director of Nursing / Assistant Administrator as needed. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Acknowledgement of care plan reviews, including family requests and orders obtained will be shared at the quality assurance committee and at scheduled IDT meetings.	3/6/17 3/10/17 3/31/17 4/12/17
4 184	11-94.1-46(a) Pharmaceutical services (a) Each facility shall employ a licensed pharmacist, or shall have a written contractual arrangement with a licensed pharmacist, to provide consultation on methods and procedures for ordering, storing, administering, disposing, and recordkeeping of drugs and biologicals, and provisions for emergency service. This Statute is not met as evidenced by: Based on record review and staff interview the facility failed to accurately discontinue a physician's order for 1 of 6 (Resident #4) residents in the Stage 2 sample list. Findings include:	4 184	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The physician of Resident #4 was notified of the medication error on 2/10/2017 and a clarification order was obtained. An event report was completed on 2/10/2017 by the nursing staff and submitted to the Director of Nursing / Assistant Administrator, who in turn contacted the Administrator that same day. 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 having adequate measures in place to assure that they receive medications appropriately as ordered. A review for accuracy of all ordered medications against the medication administration records for residents was completed on 2/24/2017.	2/10/17 2/10/17 2/24/17

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4 184	Continued From page 6 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.	4 184	WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The correct process for discontinuing medications was reviewed with staff and begun on 2/24/2017 and is expected to be completed by 3/10/2017 – this includes 1) the requirement for each staff to review new physician orders from the prior sheet to validate the proper transcription of physician orders, 2) the modification of the current medication administration record, and 3) the requirement for review / modification for accuracy and signature of staff prior to initiating a pre-printed medication administration record from the remote pharmacy. The Long-Term Care Coordinator will review include an extra review medication administration records at the beginning of each month to assure accuracy / make necessary corrections and complete event reports as needed. Results of these audits will be shared in real-time with the Director of Nursing / Assistant Administrator for appropriate action. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The Long-Term Care Coordinator will report the results of the audits at quality assurance meetings and the Director of Nursing / Assistant Administrator will report on event reports and actions taken.	2/24/17 3/10/17 4/7/17 4/12/17
4 193	11-94.1-46(j) Pharmaceutical services (j) Medication errors and drug reactions shall be recorded in the resident's chart and reported immediately to the physician, physician assistant, or APRN who ordered the drug, and a medication error report shall be prepared and given to the administrator of the facility or director of nursing for review and appropriate action, according to facility policy. This Statute is not met as evidenced by: Based on record review and staff interview the facility failed to accurately discontinue a physician's order for 1 of 6 (Resident #4) residents in the Stage 2 sample list.	4 193	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The physician of Resident #4 was notified of the medication error on 2/10/2017 and a clarification order was obtained. An event report was completed on 2/10/2017 by the nursing staff and submitted to the Director of Nursing / Assistant Administrator, who in turn contacted the Administrator that same day. 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 having adequate measures in place to assure that they receive medications appropriately as ordered. A review for accuracy of all ordered medications against the medication administration records for residents was completed on 2/24/2017.	2/10/17 2/24/17

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4 193	Continued From page 7 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.	4 193	WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The correct process for discontinuing medications was reviewed with staff and begun on 2/24/2017 and is expected to be completed by 3/10/2017 – this includes 1) the requirement for each staff to review new physician orders from the prior sheet to validate the proper transcription of physician orders, 2) the modification of the current medication administration record, and 3) the requirement for review / modification for accuracy and signature of staff prior to initiating a pre-printed medication administration record from the remote pharmacy. The Long-Term Care Coordinator will review include an extra review medication administration records at the beginning of each month to assure accuracy / make necessary corrections and complete event reports as needed. Results of these audits will be shared in real-time with the Director of Nursing / Assistant Administrator for appropriate action. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The Long-Term Care Coordinator will report the results of the audits at quality assurance meetings and the Director of Nursing / Assistant Administrator will report on event reports and actions taken.	2/24/17 3/10/17 4/7/17 4/12/17
4 214	11-94.1-55(a) Housekeeping (a) Each facility shall have a plan for routine periodic cleaning of the entire building and premises. □ This Statute is not met as evidenced by: Based on interview and observation, the facility failed to maintain equipment in safe operating condition. 1) On 2/10/17 during kitchen tour, it was noted that the main basin that dishes are washed had rust along the perimeter of sink and leaks. Interview with SM#4 stated that a request was	4 214	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The kitchen basin and hand-washing sinks were re-caulked and cleaned on 2/23/2017. Neither of the sinks leak or are in danger of failure. The temperature of the food storage area has been monitored and a literature search conducted to review 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 remaining shower chairs were assessed and not found to have rust or other signs of maintenance needs. No additional shower chairs were determined to be needed at this time. 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 that essential equipment is in safe operating conditions. A review of the facility equipment operation was completed on 3/7/2017 and appropriate actions for correction were taken.	2/23/17 2/10/17 3/7/17

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	125023	A. BUILDING: _____ B. WING _____	02/10/2017

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4 214	Continued From page 8 submitted to have the sink recaulked on 2/4/17. SM#4 verbalized that their was also concern that when filling sink with water that the sink may collapse because of the rust. It was also observed that the handwashing sink was leaking under sink seal areas. On further interview, SM#4 stated that storage area maintained with a manual fan for correct temperature because it will get too hot for food storage. SM#4 stated the concern that the fan is not working correctly and if it breaks, termperature will become too hot for food storage. On 2/10/17 at 10:00, discussed these observations with SM#1 who stated that she would look into these concerns. 2) On 2/9/17 during an interview with Resident #4 (Res #4) surveyor noticed the shower chair in resident's shower stall that had rust on it. All four metal legs had rust up to the area that meets the seat. On the morning of 2/10/17 SM #3 was interviewed and asked if the shower chair in Res #4's room is currently being used for the resident and he acknowledged that is was. SM #3 stated that new shower chairs had been purchased and needed to be switched out. Staff member #1 was interviewed about replacement shower chairs and she acknowledged that new shower chairs had been purchased. In summary, the facility failed to maintain equipments for resident care in a safe operating condition.	4 214	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. Started on March 7, 2017 to be completed weekly. 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. The results of the weekly walk-through of the facility audit will be shared in real-time with the Director 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.	3/7/17 2/14/17 3/7/17 4/12/17
4 218	11-94.1-55(e) Housekeeping (e) All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair.	4 218		

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4 218	Continued From page 9 This Statute is not met as evidenced by: Based on interview and observation, the facility failed to maintain equipment in safe operating condition. 1) On 2/10/17 during kitchen tour, it was noted that the main basin that dishes are washed had rust along the perimeter of sink and leaks. Interview with SM#4 stated that a request was submitted to have the sink recaulked on 2/4/17. SM#4 verbalized that their was also concern that when filling sink with water that the sink may collapse because of the rust. It was also observed that the handwashing sink was leaking under sink seal areas. On further interview, SM#4 stated that storage area maintained with a manual fan for correct temperature because it will get too hot for food storage. SM#4 stated the concern that the fan is not working correctly and if it breaks, termperature will become too hot for food storage. On 2/10/17 at 10:00, discussed these observations with SM#1 who stated that she would look into these concerns. 2) On 2/9/17 during an interview with Resident #4 (Res #4) surveyor noticed the shower chair in resident's shower stall that had rust on it. All four metal legs had rust up to the area that meets the seat. On the morning of 2/10/17 SM #3 was interviewed and asked if the shower chair in Res #4's room is currently being used for the resident and he acknowledged that is was. SM #3 stated that new shower chairs had been purchased and needed to be switched out. Staff member #1 was interviewed about replacement shower chairs and she acknowledged that new shower chairs had	4 218	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The kitchen basin was and hand-washing sinks were re-caulked and cleaned on 2/23/2017. Neither of the sinks leak or are in danger of failure. The temperature of the food storage area has been monitored and a literature search conducted to review 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 remaining shower chairs were assessed and not found to have rust or other signs of maintenance needs. No additional shower chairs were determined to be needed at this time. 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 that essential equipment is in safe operating conditions. 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. Started on 3/7/2017 to be completed weekly. 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. The results of the weekly walk-through of the facility audit will be shared in real-time with the Director 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.	2/23/17 2/10/17 3/7/17 3/7/17 2/14/17 3/7/17 4/12/17

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4 218	Continued From page 10 been purchased. In summary, the facility failed to maintain equipments for resident care in a safe operating condition.	4 218	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 2/10/2017. Staff was re-educated to notify the Director or Nursing / Assistant Administrator of maintenance needs if they are not promptly addressed.	2/10/17
4 243	11-94.1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by: Based on interview and observation, the facility failed to provide a sanitary environment for residents, staff and public. On 2/08/17 at 0900 A.M. during an initial kitchen tour, it was noted that two fans above the dishwashing sinks were prominent with dust and needed to be cleaned. SM#4 stated that they have not been cleaned on a regular basis and did not have a service log. On 2/10/17 at 0830 A.M. during a follow-up kitchen tour, it was noted that the two fans above the dishwashing sinks were still covered with dust. SM#4 stated that a request was sent for the fans to be cleaned. On 2/10/17 at 10:00, discussed these observations with SM#1 who stated that she would look into these concerns and that housekeeping takes care of this. In summary, the facility failed to provide a clean and sanitary environment for their staff and residents.	4 243	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 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. The results of the weekly walk-through of the facility audit will be shared in real-time with the Director 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.	3/7/17 3/7/17 2/14/17 3/7/17 4/12/17

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4 244	Continued From page 11	4 244	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.	2/10/17
4 244	11-94.1-64(b) Engineering and maintenance (b) The facility shall have an appropriate written preventive maintenance program. This Statute is not met as evidenced by: Based on interview and observation, the facility failed to provide a sanitary environment for residents, staff and public. On 2/08/17 at 0900 A.M. during an initial kitchen tour, it was noted that two fans above the dishwashing sinks were prominent with dust and needed to be cleaned. SM#4 stated that they have not been cleaned on a regular basis and did not have a service log. On 2/10/17 at 0830 A.M. during a follow-up kitchen tour, it was noted that the two fans above the dishwashing sinks were still covered with dust. SM#4 stated that a request was sent for the fans to be cleaned. On 2/10/17 at 10:00, discussed these observations with SM#1 who stated that she would look into these concerns and that housekeeping takes care of this. In summary, the facility failed to provide a clean and sanitary environment for their staff and residents.	4 244	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.	3/7/17
			HOW 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 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.	3/7/17 2/14/2017 3/10/17 3/24/17
			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