STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING: _____ B. WING _____	01/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

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4 000	11-94.1 Initial Comments An onsite Federal recertification survey was conducted at the facility from January 10-13, 2017. At the time of entrance, the resident census was 119. Event reports #4031 and #4032 were investigated.	4 000		
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 observation and interview with staff member, the facility failed to care for 6 (Residents #6, #54, #181, #2, #25, and #167) of 29 residents in the Stage 2 sample in a manner that promotes their quality of life recognizing each resident's individuality. Findings include: 1) The facility did not ensure four residents (Residents #28, #167 and #6) were provided care in a dignified manner as evidenced by residents being transported through the halls to and from the shower rooms draped in sheets and towels	4 115		

C:GL 2/14/17 & 2/28/17 - copy scanned to RN's ion

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4 115	Continued From page 1 while there are visitors, staff members and other residents present. On 1/10/17 at 11:07 A.M. observed Resident #28 being wheeled past the nurse's station in a bath chair. The resident was draped with a sheet to cover the front of her body. The back of the chair was not draped, exposing the commode bucket hanging from the seat. The Certified Nursing Aide #2 (CN#2) parked the resident outside of shower room B and left. The shower room was being used by Resident #138. Resident #138's visitor was observed standing in the hall outside of the shower room. The visitor spoke with Resident #28, inquiring whether she was waiting for a shower and commented that it will feel good to have a shower. Another resident was observed to wheel past Resident #138 as she was waiting for a shower. At 11:11 A.M. CNA#2 returned and draped the sheet to cover the back of the shower chair. At 11:12 A.M. Resident #28 was observed to be wheeled to another shower room A at the end of the hall. On 1/12/17 at 1:35 P.M. observed Resident #167 being wheeled to the room in a bath chair by CNA#3. Resident #167 was dressed in a hospital gown with a sheet draped over the front of her body with a towel hanging at the back of her shower chair. As the resident and staff member approached the resident's room, a maintenance staff member was buffing the floor. The resident had to be wheeled past the male staff member. On 1/11/17 at 11:15 A.M. an interview was conducted with the Director of Nursing (DON). The observation of Resident #28 was shared with the DON. The DON reported that four minutes is a long time to wait for a shower while seated in the hall, probably the shower room that was	4 115	1-1 Caregivers for residents #28, #167, and #6 were re-educated immediately to ensure dignified care when transporting residents to shower rooms 1-2. DON, Nurse Managers and/or designee will review and evaluate current shower/bath procedures and revise as needed to ensure the comfort, dignity, and safety for all residents. 1-3. All staff involved in resident care will be in-serviced on the existing and revised procedures. 1-4. The DON/designee will conduct random checks 5 times a week for at least 4 weeks then randomly thereafter to ensure that staff are properly following the new or revised shower/bath procedures. Any non-compliance will be resolved immediately and non-compliance will be reported at Quarterly QA.	1/10/2017 though 1/12/2017 02/24/2017 03/11/2017 Ongoing

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4 115	Continued From page 2 closer to the resident's room was not available. The DON further reported that the staff member should not be doing this and it is "undignified". 2) On 1/12/2017 at 10:20 AM observed Res #6 seated in a wheelchair and being wheeled pass the nurses station for an outside appointment. The resident's hair was not combed. The observation was pointed out to LN #6 . The LN #6 left the nurse station and returned to comb the resident's hair. Later that day at 1:43 PM discussed the incident with the same licensed nurse. The licensed nurse agreed that it was not dignified to be going out on an appointment without being properly groomed and had spoken to the CNA assigned to Res #6 about adequate grooming. 3) On 1/11/2017 at 8:44 AM observed a CNA #1 assisting Res #54 with the resident's breakfast meal. Res #54 was laying in bed with the head of bed up. The CNA #1 was standing over Res #54 holding a spoon and feeding the resident. When asked about standing while assisting a resident with feeding the CNA #1 responded, "I should be sitting when feeding". Later that day the DON was interviewed regarding assisting a resident with feeding, the DON stated, "should be at eye level for the comfort of the resident." 4) On 01/11/2017 at 9:04 A.M. an interview was done with resident #181 (Res #181). Record review of of the Minimum Data Set (MDS) dated 12/27/16 for Res #181. In Section C, Cognitive level noted the resident scored a 15 on the Brief Interview for Mental Status (BIMS). BIMS is a brief screener that aids in detecting cognitive impairment in which 13-15 is cognitively intact. Res #181 stated "sometimes it takes a while at nights to answer the call light. They say they only	4 115	2-1. Grooming of resident #6 was completed immediately. CNA assigned was re-educated to ensure that residents are properly groomed everytime they are brought out of their rooms. 2-2. All residents who are out of their rooms whether for an appointment, activity, or dining, or any other reason, will be properly groomed and neatly dressed to ensure their dignity. 2-3. During their daily rounds, the licensed nurses assigned to each resident will check to make sure the resident is properly groomed and neatly dressed as needed to maintain their dignity. 2-4. Unit Managers will monitor on a daily basis that residents are properly dressed and groomed. Any non-compliance will be resolved immediately including re-education of staff. Non-compliance will be reported to Quarterly QA Meeting. 3-1. CNA#1 was counseled and re-educated regarding the proper procedures for assisting the residents during meals. For example, sitting at the resident's eye level, not rushing the resident, and other means of ensuring the resident's comfort and dignity. 3-2. All staff involved in residents' dining experience were reminded to follow the proper dining protocol. 3-3. Dining services on all units and shifts will be evaluated by the Nursing Supervisors to check that all aspects of the dining experience meet proper dining room protocol. An in-service will be provided to educate staff regarding proper dining room protocol. 3-4. The DON/designee will use the Dining Service Experience survey form by CMS to monitor that all staff are following the proper procedures weekly X 4. Then randomlythereafter depending on outcome. Any non-compliance will be reported to the Quarterly QA Meeting. 4-1. The Nursing Supervisor, DON, Licensed Nurse spoke with resident #81 to review resident's toileting needs. Care plan was revised to reflect resident's needs. 4-2. All residents will be assessed for bowel and bladder function on admission, annually, and when a condition change occurs. Care plans will be revised based on assessment and care staff will be notified immediately and during endorsement.	01/12/2017 Ongoing Ongoing Ongoing 01/16/2017 01/27/2017 03/11/2017 Ongoing 01/16/2017 03/11/2017

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4 115	Continued From page 3 have two nurses to cover a lot of residents but when they do come, they clean me up pretty well. Day time, they come within four minutes and night time sometimes it feels like eternity. If they busy with their rounds, they tell me to go in my diaper". When asked if that is what he does at home, he stated no. Resident further stated that the facility told him they ran out of rails, so he has nothing to grab to turn in his bed and hold onto. He stated he has something to grab onto at home. The facility told him that they ordered some rails but that was a week ago. On 01/11/17 at 11:00 A.M. interview with LN#3 regarding toileting hygiene for Res#181 was discussed. LN#3 was informed of the decline in toileting hygiene since his admission of 12/20/16. When asked about a grab bar to assist with toileting, LN#3 did not have an answer but that she would check into this. On 01/13/17 at 10:15 A.M. an interview with DON and administrator was done. Both the administrator and DON acknowledged that this was not the standard of practice. 5) On January 10, 2017 at 7:30 AM Resident #2 (R #2) was observed sitting in the hallway outside the 3rd floor unit shower room seated on a shower chair wearing a hospital gown. It was noted that a sheet was draped on R #2 and tied around the back of the shower chair. This was witnessed by staff and other residents who walked/rolled past resident. At that time the shower room was being used by Resident #61 (R #61).	4 115	4-3. The nursing staff will communicate all resident care concerns using Interact "Stop and Watch" form. 4-4. The Nurse Managers will monitor all "Stop and Watch" forms to ensure timely implementation of interventions. Any incomplete items will be resolved immediately and reported quarterly at the Quarterly QA Meeting. 5-1. All staff caring for resident #2 were re-educated to ensure that resident was properly clothed and treated in a dignified manner prior to, during, and after bath/shower. 5-2. Current shower/bath procedures will be reviewed and evaluated by Nurse Managers and evaluated as needed to ensure the comfort, dignity, and safety of all residents. 5-3. All nursing staff will be in-serviced on any changes to current shower/bath procedures. 5-4. The DON/designee will conduct random checks 5 times a week for at least 4 weeks to ensure that staff are properly following the new shower/bath procedures. Any non-compliance with the new shower/bath procedures will be resolved immediately and reported at the Quarterly QA Meeting.	03/11/2017 03/11/2017 and Ongoing 01/10/2017 03/11/2017 03/11/2017 03/11/2017 and Ongoing
4 136	11-94.1-30 Resident care	4 136		

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4 136	Continued From page 4 The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on medical record review (MRR), staff interviews and resident observation, the facility failed to ensure that the licensed nurses had general knowledge and understanding of skin care and services provided, for 1 of 29 residents (R#146) on the Stage 2 survey sample resident list. Findings include: On 01/11/2017 at 1:39 PM conducted MRR on R#146. The resident was admitted to the facility on 11/10/2016 and the nursing skin assessment done documented that R#146 had excoriation to the coccyx area. The nursing admission skin assessment done on 11/10/16 noted excoriation to coccyx area with measurements of "1.0 x 0.5 cm; 0.3 x 0.1 cm and 0.7 x 0.7 cm." The Physicians Orders (PO) form for January 2017, had under the "Orders" column dated	4 136	1. The Nursing Supervisor and Charge Nurse re-assessed and corrected the wound characterization based on the facility's skin integrity program algorithm and reported the findings to the attending physician. The care plan and interventions were reviewed and revised based on current measurements and wound status as needed to prevent infection and provide proper treatment. 2. Re-training has been scheduled for all licensed nurses (LN) as "Skin Care Champions" for each unit. The LN will be trained to provide consistent assess ments, properly characterize wounds, promote proper skin care procedures,and improve both care	01/16/2017 02/09/2017

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4 136	Continued From page 5 "11/10/2016 Apply Aloe Vesta to excoriation on buttocks Q shift until healed." On R#146's Admission History & Physical form dated 11/10/16, the review of systems (ROS) for dermatological review noted that the resident had no rash or skin breakdown. On 01/12/2017 at 9:34 AM interviewed LN#4 and discussed R#146's excoriation to coccyx with measurements (1.0 x 0.5 cm; 0.3 x 0.1 cm; and 0.7 x 0.7 cm), and LN#4 stated that excoriation doesn't mean break in skin, but redness due to incontinence. Discussed that the resident's admission minimum data set (MDS) 3.0 was not coded for Stage 1 (non-blanchable redness) and/or moisture associated skin damage (MASD) (e.g. incont-associated dermatitis [IAD], perspiration, drainage); as the nursing admission skin assessment sheet on 11/10/16 noted excoriation. The most recent skin assessment dated 01/06/2017 with a human figure drawing, noted on the coccyx all excoriation with an arrow pointing to the coccyx area; and notations of "skin re-open"; and apply sensi care aloe vesta cream. LN#4 could not explain the facility's definition of excoriation and had to ask her supervisor. On 01/12/2017 at 1:18 PM observed LN#5 provide treatment to the coccyx for R#146 per physician order. The resident had broken skin on the coccyx with a red pink wound bed and whitish skin tissue surrounding the wound. The LN#5 stated that nurses used the wrong word to describe the resident's "excoriation" because coccyx had denuded areas with healing dry skin. The LN#5 referred to the facility's "3 Step - Skin	4 136	(cont'd.) and prevention of wounds. Each Skin Care Champion will serve as the resource/educator for their unit. 3. Current policies and procedures will be reviewed and revised accordingly, with guidance from a wound care specialist/educator, to ensure proper wound care and treatment based on the most current standard of practice. Weekly meetings will be held with the Skin Care Champions, Nursing (LN and Restorative Nursing Aide), Registered Dietitian to discuss current residents receiving wound care. 4. The Nursing Managers will monitor skin care procedures and documentation. Any issues will be resolved immediately. Any problematic trends will be reported at the Quarterly QA Meetings.	03/11/2017 02/15/2017 and Ongoing 03/11/2017 and Ongoing

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4 136	Continued From page 6 Integrity Program" sheet that they used for reference, to describe the difference between denuded and MASD due to incontinence. The LN#5 stated that R#146 had more denuded skin because resident's skin in contact with wet brief and not changed right away. There were two little blisters on the resident's buttocks near to the coccyx area noticed during the observation and LN#5 stated that this is the first time observing the blisters. On 01/13/2017 at 9:35 AM interviewed the DON and discussed how LN staff documented R#146's skin condition as "excoriation" but when queried the LN staff had different description of skin condition (e.g. denuded, MASD), and there was no coding of skin condition in the resident's MDS 3.0. The DON explained that LN staff received wound care education from a contracted wound care specialist and educator. The DON was not sure whether the LN that did the resident's admission skin assessment was trained, but was certain that LN#4 received wound care training and should have known the algorithm of skin conditions used at the facility. The DON stated that the facility had no policy/procedure for treatment of skin conditions and/or pressure ulcers. The facility used the "3 Step - Skin Integrity Program" and "Pressure Ulcer Staging" sheets for licensed nurses to use as reference. These sheets were developed by ConvaTec Solutions Programs, and included pictures with descriptions of compromised skin such as incontinence - raw skin (IAD/MASD), denuded and weeping skin, and pressure ulcers in different stages (Stage I - IV). The DON stated that there was no picture or explanation on the skin reference sheets for skin "excoriation, " and she was not aware that the	4 136		

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4 136	Continued From page 7 licensed nurses were describing skin conditions as "excoriated." Discussed with DON that the MDS 3.0 skin condition section also does not use "excoriation" as a descriptor but included IAD/MASD. The skin condition on R#146's coccyx was not comprehensively care planned by a licensed nurse with qualifications and understanding of skin conditions and wound care.	4 136		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided.	4 149		

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4 149	Continued From page 8 This Statute is not met as evidenced by: Based on medical record review (MRR), observations and staff interviews the facility failed to implement interventions to prevent falls for 2 of 29 residents (R#20, R#125) on the survey Stage 2 sample resident list. Findings include: 1) An event report for R#20 was received by the Office of Health Care Assurance (OHCA) on 12/13/2016, to report that on 12/11/2016, the R#20 fell from her wheelchair onto the floor and sustained a laceration above the right eye brow area. On 01/11/2017 at 2:48 PM the MRR on R#20 found that she had a "Risk for Fall," care plan (CP) dated 10/23/15, related to poor safety awareness and cognitive impairment due to diagnosis of dementia, [redacted] vision impairment and impaired balance/gait. The goal written on 12/11/16 "Resident safety will be maintained as evidenced by: Fall will be avoided; no serious outcomes from fall over the next 90 days; Serious outcomes from falls will be addressed immediately to prevent further complications; 12/11/16 Unwitnessed fall with laceration on R eyebrow measuring 3.5 cm." The CP interventions included, "Use of personal or pressure sensors alarms as indicated and answer promptly; Apply seatbelt while up in wheelchair for safety; while OOP with family or with activity; place resident in front of the table." On 01/12/2017 at 10:26 AM observed R#20 being wheeled to a table in the activity/dining room by AA#1 and noticed that the resident's seat belt	4 149	1. The care plans for residents #20 and #125 were reviewed and revised to specify interventions appropriate to prevent falls and ensure that all caregivers clearly understand the required fall prevention measures for these residents. 2. The care cards information used by the CNAs will be available to all disciplines so that ID Team members are familiar with the resident's specific care needs, including fall prevention. Licensed Nurses will ensure care cards are routinely updated. 3. All resident care staff will be inserviced on resident fall prevention and resident safety measures including documentation on care cards and resident care plans. SBAR will be used to communicate any fall prevention interventions to all related disciplines. 4. Nursing Supervisors will monitor documentation and coordination of resident fall prevention interventions and safety measures. Any issues will be resolved immediately and reported to Quarterly QA Meeting.	01/27/2017 03/11/2017 and Ongoing 03/11/2017 and Ongoing 03/11/2017 and Ongoing

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4 149	Continued From page 9 was not on and didn't notice a chair alarm. Queried AA#1, whether R#20 was wearing a seatbelt and she stated that R#20 should be wearing a seatbelt. When AA#1 checked to see that the resident had the seatbelt on, she found that the seatbelt was not secured and buckled the seatbelt for the resident. The AA#1 stated that CNA#2 was assigned to the Res and she placed the resident into the wheelchair and brought her into the activity/dining rm. The Res was placed at the table for Bingo activity. On 01/12/2017 at 11:46 AM interviewed LN#1 to discuss R#20's CP and implementation of interventions. According to LN#1, R#20's personal alarm was discontinued on 01/05/17 because the resident now used a seat belt when placed in a wheelchair. The LN#1 further stated that CNA#2 was a floater and was not familiar with the resident's CP. On 01/12/2017 at 3:03 PM interviewed CNA#2 and queried her about R#20 and wheelchair use. According to CNA#2, she prepared the seat belt but forgot to buckle it and that there is no alarm for the resident's wheelchair. CNA#2 stated that she was employed at the facility since March 2016 and floats between floors. On 01/12/2017 at 3:05 PM interviewed LN#1 and asked how CNAs know when CPs change and she stated that CNAs are informed through a special endorsement book for CNAs. The special endorsement book, had a column for personal alarm, and the CNAs would place a check mark in the column for R#20, but the wheel chair personal alarm column had "N/A" written in. In the CNAs "Care Plan Reference" sheet there was no indication that the CNAs should buckle the seat belt when placing R#20 in the wheelchair.	4 149		

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4 149	Continued From page 10 On 01/12/2017 LN#1 revised R#20's CP dated 12/12/16, "Resident is at risk for injury from entrapment of head, neck and limbs of upper and lower extremities from padded siderail; trunk restraint; lap buddy; seat belt on wheelchair." On 01/12/2017 the revised CP intervention included: "Release seat belt when Res seating in front of table or when engaging with activities with visual supervision." On 01/13/2017 at 6:47 AM interviewed LN#1, and according to her, R#20 was in the activity/dining rm when she fell face forward onto the floor from her wheelchair. LN#1 had her back to R#20, who was sitting in her wheelchair and leaning to her right. According to LN#1, prior to R#20 falling forward from her wheelchair, she was running fevers from 11/30/16 with temperatures at 101 degrees Fahrenheit (F), kept eyes closed and was on hospice care. On 12/11/2017, the day of the fall, R#20 was feeling better, opened her eyes and had no fever, so was brought to the activity/dining rm. The Res' daughter was contacted immediately after the fall for permission to take R#20 to an emergency room (ER) to stop the bleeding from the laceration sustained from the fall. R#20's temperature was at 101 degrees F at the ER but post-fall at the facility, her temperature was recorded at 98 degrees F. According to LN#1, because R#20 only laid in bed prior to her 121/11/2016 fall, her upper extremities were weak when placed in the wheelchair and staff didn't anticipate that Res would fall forward. The Res was admitted to the facility on 10/15/15 and had no falls until 12/11/16. The Res CP revision on 01/12/2017, was to place the resident at the table with direct	4 149		

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4 149	Continued From page 11 supervision or the seat belt should be secured. Informed the LN, that the CP revision was done after it was brought to their attention that facility staff were not implementing interventions as care planned to prevent further falls.	4 149		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation, interview, and policy review the facility failed to distribute and serve food in accordance with professional standards for food service safety. Findings includes: 1) (cross from F 241 for Resident #54) On 1/11/2016 at 8:44 AM observed CNA #1 standing next to the bed of Res #54 assisting the resident with feeding. CNA #1 was holding a spoon and observed spooning small amounts of food into the resident's mouth. During the observation CNA #1 put the spoon down onto Res #54's tray and walked over to Res # 28 who was in the same room, in bed feeding him/herself. Without	4 159	1-1. CNA#1 was counseled and re-educated regarding the proper procedures for assisting residents during meals. For example, sitting at the resident's eye level, not rushing the resident, and any other means of ensuring the reisdent's comfort and dignity. 1-2. All staff involved in residents' dining experience were reminded to follow the proper dining room protocol. 1-3. Dining services on all units and shifts will be evaluated by the Nursing Supervisors to check that all aspects of the dining experience meet proper dining room protocol. An in-service will be provided to educate staff regarding proper dining room protocol. 1-4. The DON/designee will use the Dining Service Experience survey form by CMS to monitor that all staff are following the proper procedures weekly x 4 then randomly thereafter depending on outcome. Any non-compliance will be reported to the Quarterly QA Meeting.	01/16/2017 01/27/2017 03/11/2017 Ongoing

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4 159	Continued From page 12 hand sanitizing CNA #1 touched two bowls of food on Res #28's tray, moving the two bowls closer to the resident. Immediately after the observation CNA #1 was asked about hand sanitizing between resident care, CNA #1 stated, "I should have washed my hands, because of contamination". On 1/11/2016 at 2:28 PM the DON was interviewed regarding feeding the resident while standing and hand hygiene between resident care. The DON acknowledged that the staff should be assisting with feeding at eye level for the comfort of the resident and there should be hand hygiene between resident care. The facility policy titled "Handwashing" under Procedures states handwashing or hand antisepsis should be, "Before and after resident contact." 2) During lunch observation on 01/10/2017 at 11:50 AM Activity Assistant #1 (AA #1) was seen discarding trash, pushing the trash down with her bare hands, without doing hand hygiene proceeded to handout lunch trays to residents, opening the lids from the containers on the meal trays. This occurred two times. The facility policy on Handwashing Infection Control Policy and Procedure was reviewed. Under Procedure A. Health Care Personnel Handwashing and Hand Antisepsis #2 it states "If running water and soap is not immediately available; hand antisepsis may be accomplished with alcohol-based handrubs (if hands are not visible soiled): i. Before and after resident contact. ii. After contact with a source of microorganism (body fluids and substances, mucous membranes, non-intact skin, inanimate objects that are likely to be contaminated)."	4 159	1. Both CNA's in question were counselled and re-educated regarding the facility's policies and procedures for infection control during meal service. 2. All staff will be in-serviced regarding Sanitation and Infection Control Policies and Procedures during meal service. 3. Sanitation and Infection Control Policies and Procedures for meal service will be incorporated into Nursing Orientation and annually during staff in-services on infection control. 4. The DON/designee will monitor Sanitation and Control Procedures during meal service quarterly and report findings at the next Quarterly QA meetings.	01/16/2017 03/11/2017 03/11/2017 and Ongoing Ongoing

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4 159	Continued From page 13 An interview of the DON on the afternoon of 01/13/2017 revealed that all staff are required to do hand hygiene before and after serving each lunch tray and after throwing away trash.	4 159		
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, observation, and interview the facility failed to keep a resident's drug regimen free from unnecessary drugs for one of 37 sampled in Stage 2 of the survey. Resident #160 (Res #160) Finding includes: On 1/10/2017 at 11:14 AM observed Res #160 in bed, watching TV. When greeted Res #160 smiled and pointed in a non verbal response. On 1/10/2017 at 3:08 PM a record review confirmed Res #169 was diagnosed as non verbal. A medication review of Res #160's record found the resident was admitted on 12/23/2016 with admission orders that included Sertraline (Zoloft) to be given at bedtime for situational depression. Further review found the following: 12/23/2016 Nursing admission note, "pt seemed cheerful and appropriate while assessing." 1/4/2017 physician note, "psychiatric/behaviors: negative for depression, the pt is not nervous/anxious". A review of the resident's Behavior/Intervention	4 184	1. For resident #160, the use of antidepressant was re-evaluated and a gradual dose reduction was initiated as ordered by the physician. The ID team reviewed and revised the resident's care plan accordingly. 2. All residents listed in the monthly report received from the pharmacy and residents scheduled for care conferences will be reviewed to ensure that the medications are monitored using the Mood/Behavior Monitoring Log 3. Nurse Managers will review care plans for all residents on psychoactive medications to ensure team members use non-pharmacological interventions before resorting to psychoactive medications to address mood/behavior concerns. The DON or Designee, withthe assistance of the pharmacy consultant will evaluate all psycho-active medications used by each resident and monitor any changes to ensure that no unnecessary drugs are used. 4. The DON or Designee will monitor psychoactive medication regimens to ensure non-pharmacological interventions are in place. Any issues of non-compliance will be reported to the appropriate nursing supervisor for follow up. Outcomes will be reported at the Quarterly Quality Assurance Meetings.	01/16/2017 01/27/2017 03/11/2017 and Ongoing 03/11/2017 and Ongoing

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4 184	Continued From page 14 Monthly Flow Record found daily monitoring of the resident's depression started on 1/1/2017. There was no documentation found for monitoring of the resident's depression when Zoloft was started on 12/23/2016 to 12/31/2016. The resident's care plan #13 Depression dated 1/8/2017 states, "Started on Zoloft for depression during hospitalization." On 1/11/2017 at 2:12 PM the DON was interviewed regarding monitoring for depression while on Zoloft. The DON acknowledged the behavior monitoring form should have been used when the medication was started.	4 184		
4 205	11-94.1-53(b)(2) Infection control (b) The facility shall have provisions for isolating residents with infectious diseases until appropriate transfers can be made. (2) At least one single bedroom shall be designated as an isolation room as needed and shall have: (A) An adjoining toilet room with nurses' call system, a lavatory, and a toilet; (B) Appropriate hand-washing facilities available to all staff; and (C) Appropriate methods for cleaning and disposing of contaminated materials and equipment; This Statute is not met as evidenced by: Based on observation and interview with staff members, the facility failed to implement and	4 205		

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4 205	Continued From page 15 maintain an infection control program to prevent the spread of infection within the facility. Findings include: 1) During the initial tour on 1/10/17 at 8:00 A.M. observed in shower room C on the second floor, a blue shower chair with the foot rest covered with mottled black substance. A concurrent observation was made with a Licensed Nurse #8 (LN#8). LN#8 was asked what is the black substance on the footrest, LN#8 replied the shower chair is old. Also, inquired what the reddish brown mark was toward the back of the footrest under the hole for the commode bucket. LN#8 was not sure. LN#8 reported that housekeeping and maintenance cleans the shower chairs. Subsequently, at 10:22 P.M. LN#3 reported that the shower chairs are cleaned before it is used for the residents, after 9:00 A.M. Subsequent observation found the blue shower chair was removed from the shower room. On 1/13/17 at 9:00 A.M. an infection control interview was done with the Director of Nursing (DON). The DON reported the facility does not have a policy regarding cleaning and disinfecting of the shower chair/equipment. The DON reported it is a standard practice that if the shower equipment is dry it was cleaned previously by staff (probably the night before); however, if the equipment is wet, it was used and would indicate to staff the equipment was used. 2) On 1/10/2017 at 9:56 AM observed CNA #1 wearing gloves to adjust the arms and sleeves of Res #28 who was resting in bed. CNA #1 then removed the gloves and failing to hand sanitize walked over to Res #54 who was in bed in the same room and touched Res #54. Immediately	4 205	1-1. The shower chair was immediately cleaned and disinfected by housekeeping staff. Other shower chairs and gurneys were all checked and cleaned/disinfected as needed by the Housekeeping Department. All units and shifts were reminded on the proper infection control procedures for shared items/equipments. 1-2. All items/equipments that are shared among the residents were identified, checked and cleaned/disinfected. 1-3. The DON and the Environmental Services Department will develop a Policy and Procedure to identify and properly clean/disinfect shared items/equipment to promote infection control practices and help prevent the spread of infection. 1-4. The DON/designee as the Facility Infection Preventionist, will monitor this infection control program 4 times monthly in the next quarter then randomly thereafter to ensure compliance. Any non-compliance will be resolved immediately. Any problematic issues will be reported to the Quarterly QA meeting. 2.1 CNA #1 was counselled and re-educated on proper glove use and hand hygiene. 2.2 All staff will be inserviced regarding PPE use and hand hygiene. 2.3 ID Team will conduct random observations of PPE use and hand hygiene and immediately correct any non-compliance. 2.4 ID Team will track and trend observations results regularly and report any problematic issues with non-compliance at the Quarterly QA Meeting.	01/10/2017 01/16/2017 03/11/2017 Ongoing 01/13/2017 03/11/2017 03/11/2017 and Ongoing 03/11/2017 and Ongoing

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4 205	Continued From page 16 after the observation CNA #1 was asked about hand sanitizing after removing gloves. CNA #1 stated, "I forgot to hand wash". On 1/11/2017 at 2:27 PM the DON was interviewed and there should be hand sanitizing between resident contact for infection control and after removal of gloves. A review of the policy titled "Handwashing" states under Procedure, hand washing or hand antisepsis should be "before and after resident contact; after removing gloves".	4 205		
4 247	11-94.1-65(a) Construction requirements (a) The facility's buildings shall be constructed and equipped to protect the health and assure the safety of residents, personnel, and visitors. This Statute is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure that residents did not have access to toxic chemicals. Findings include: On 01/12/2017 in the afternoon, while doing environmental rounds with the Maintenance Staff #1 (MS #1), it was noted that the janitor closet on the fourth floor was left unlocked. During staff interview MS #1 acknowledged that the janitor closet door should be locked. The following day, on 01/13/2017 at 11:23 AM the janitor closet door on 4th floor was not locked and inside the closet was the housekeeping cart that contained multi cleaning solutions, (Peroxide Multi Service cleanser and disinfectant, Toilet Bowl cleanser and Emerel Multi Surface cleanser). The Janitor #1 returned to the closet	4 247	11-94.1-65(a) Construction Requirements 1. N/A 2. N/A 3. Involved staff were immediately counselled regarding safe storage of toxic chemicals. 1/13/2017 Director of Environmental Services conducted a department meeting, notifying staff that housekeeping carts are no longer to be stored in the janitor's closet at anytime during their shift. Staff were also notified to close and lock janitor's closets at each use. 2/7/2017 Daily rounds will be conducted by the lead Maintenance person to ensure all janitor's closets and any store rooms with toxic chemicals are locked when not in use. Ongoing Any non-compliance regarding these directives will result in disciplinary action. Policy and procedures for securing janitor's closets and housekeeping carts management and security will be developed and implemented in the next 30 days. 3/11/2017 4. Director of Environmental Services or designee will conduct random observations of policy and procedures by Environmental Services staff. Any deficiencies noted will be reported to the Safety Committee monthly. Ongoing	

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4 247	Continued From page 17 and stated he left to get "paper towel". The potential hazard of residents' access to toxic chemicals was evident by staff leaving the janitor closet unlocked.	4 247		
4 264	11-94.1-65(d)(1) Construction requirements (d) The facility shall have adequate toilet and bath facilities: (1) One toilet room shall serve not more than eight residents; This Statute is not met as evidenced by: Based on observation and staff interviews the facility failed to ensure that the call light system in the facility is functioning properly. Findings include: On the morning of 01/11/2017 prior to leaving room 309 surveyor went into the bathroom and pulled the call light cord. Call light did not activate. During staff interview LN #1 stated the cord has to be pulled hard from the bottom. LN #1 was able to activate the call light by yanking hard on the bottom of the call light cord. On the following day, on 1/12/17 in the afternoon, while doing follow up environmental rounds with MW #1, surveyor pulled the same call light cord in bathroom of room 309 and it did not activate. Call light cord had to be pulled numerous times before it alarmed. MW #1 reported that he was notified of this call light cord not working on 01/11/17. The facility policy Maintenance Policies and	4 264	11-94.1-65(d)(1) Construction requirements 1. Room 309 bathroom call light unit was replaced by facility maintenance worker 2. All call lights were rechecked by Maintenance Department to ensure proper working order. 3. Director of Environmental Services educated the maintenance staff on the importance of prioritizing work related to residents needs. Instructed crew to put resident equipment needs at the top of daily list of work. Maintenance Policy and Procedures will be amended to adjust Call Light Preventive Maintenance program from quarterly to bi-monthly to ensure equipment efficiency. 4. Director of Environmental Services will conduct random resident equipment tests and check Preventive Maintenance records during his frequent random visits to the facility to ensure in-house maintenance personnel are following all facility Maintenance Policies and Procedures, including Preventive Maintenance of all equipment. All staff will have education provided regarding the importance of vigilance and timely reporting of any equipment in need of repair. Director of Environmental Services will report all deficiencies noted to the Safety Committee monthly.	1/12/2017 1/16/2017 1/16/2017 3/11/2017 Ongoing 3/11/2017 Ongoing

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4 264	Continued From page 18 Procedures: "Facility Fixtures" was reviewed. Under procedure 1b. Nurse Call System #'s 1, 2 and 4 state: "1. Replace immediately all defective call system parts. Install or repair any call light that is missing a clip and holder. 2. Inspect system cords and wires. If defects are noted, replace as necessary. 4. Inspect all system reset switches and buttons when making monthly inspections. Repair/replace defective parts as necessary." Facility policy was not implemented.	4 264		