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
	125050	A. BUILDING: _____ B. WING _____	05/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

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4 000	11-94.1 Initial Comments A state relicensure survey was conducted at the facility from May 16, 2017 to May 19, 2017. On entrance, the census included 61 residents.	4 000	4 136 RESIDENT CARE What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations, staff interview and facility policy review, the facility failed to maintain the safety of three of three residents (Resident #36, Resident #41, and Resident #28) reviewed for accidents. Findings include: 1) Resident #28 was admitted to the facility on 3/5/15 with a diagnosis of [redacted] which is a degenerative disease that impairs a person's movement, thinking and causes psychiatric disorders. Resident #28 was admitted to a hospice program on 1/17/17 with the	4 136	➢ The MDS Coordinator will revise the care plan to include appropriate care assistance for Resident #28. ➢ The Director of Nursing (DON) will provide in-service education to all license staff regarding incident reporting. ➢ The DON will also request that the attending physician evaluate the use of antipsychotic medications. ➢ The MDS Coordinator will review Resident #36's MDS, revise the Care Area Assessment (CAA) Summary, and update the care plan. The use of a chair alarm was considered, however, due to his/her declining condition and recent admission to hospice, it was determined not to be appropriate at this time. ➢ The DON will use the task management in the new Electronic Health Record (EHR) system to ensure that approaches to prevent falls will be indicated and communicated to all Certified Nursing Assistants CNAs).	

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pauline Y Gulbran — TITLE: Administrator — (X6) DATE: 07/13/17

7.14.17 - copy to GLiban

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4 136	Continued From page 1 diagnosis of Huntington's Disease. Resident #28 was observed in the Activity Room seated in a Geri chair on the morning of 5/16/17 at approximately 9:30 A.M. She appeared fidgety, in a reclined position with her body leaning toward the right side. On the morning of 5/17/17 at 8:00 A.M. Resident #28 was in the Activity Room seated in a Geri chair in front of the TV. She was alert, quiet, in a reclined position leaning to her right side. On the afternoon of 5/17/17 at approximately 1:45 P.M., Resident #28 was observed in bed, awake. She was quiet and responsive. An interview with Staff #47 on the morning of 5/16/17 at approximately 11:00 A.M. revealed Resident #28 experienced a fall on 4/22/17 which resulted in an abrasion to her right knee. Staff #47 noted that since the fall on 4/22/17, Resident #28 was using a Geri Chair for positioning. Her diagnosis causes her to have difficulty with sitting upright without support. According to Staff #27, the facility performed a root cause analysis which determined Resident #28 required use of the Geri Chair. A medical record review found Resident #28's fall occurred on 4/23/17 at approximately 7:45 P.M. when she was found on the pad foam mat on the floor next to her bed. At the time of the fall, Resident #28 denied pain but she had a knee abrasion. She did not lose consciousness. Interview of Staff #8 regarding an incident report for Resident #28's4/23/17 fall revealed the facility did not complete an incident report. Further review found Resident #28 also fell on 4/15/17 when she was again found lying on the ground next to her bed at 4:15 P.M. An assessment of Resident #28 post fall found she had redness to	4 136	➢ The DON discussed with the family of Resident #41 about the deficient practice and a possible room change that is away from the exit door to prevent a possible elopement incident. Additionally, the door alarm will be kept on and the door will be disguised using pictures and a doorknob cover. Furthermore, the MDS Coordinator will review and revise the care plan of Resident #41. The Charge Nurse will also initiate a behavior log. How will you identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken. ➢ All current and new residents that are high risk for falls and elopement/wandering are affected by the deficient practice. ➢ The Charge Nurse will trigger an alert in the EHR system to ensure that approaches to prevent falls and possible elopement are indicated and communicated to all CNAs. ➢ The Assistant Administrator will install door alarms. What measures will be put into place or what systemic changes you will	

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4 136	Continued From page 2 both knees and a 1 cm skin tear to her right knee. She did not lose consciousness. A review of the Incident Report noted the resident's report that she slid out of her bed and landed on both knees in a kneeling position. Resident #28 was found when the staff heard alarm sounds and went to her bed to found her lying on the floor next to her bed. The facility noted corrective actions/interventions which included, "use of a recliner for monitoring (when very restless)". In addition to Resident #28's degenerative neurological disease, she was also taking psychotropic medications which could affect her balance and movement. The resident received the following medications: Seroquel (antipsychotic); Mirtazapine (antidepressant); and Sertraline (antidepressant). Although Resident #28 had two falls during the month of April 2017, a care plan for falls was not located in the resident's medical record. A review of the Minimum Data Set, MDS, on the afternoon of 5/17/17 found a significant change assessment with Assessment Reference Date (ARD) of 1/19/17 which noted that Resident #28's Care Area Assessment (CAA) Summary triggered falls. The CAA Summary further noted that falls was an existing problem and the problem was addressed in the care plans. An interview of Staff #28 on the afternoon of 5/17/17 at approximately 2:20 P.M. confirmed the facility did not have a falls care plan in place for Resident #28. Staff #28 noted the facility recently (December 2016) changed the format of the care plans and therefore the care plan may not have "transferred over" to the new system. An interview of the Director of Nursing, DON, on the morning of 5/18/17 at approximately 8:23 A.M.	4 136	make to ensure that the deficient practice does not recur. ➢ The DON will provide an annual in-service education on incident reports to all license nurses. ➢ The Social Worker Designee will check for incident report completion following each incident. ➢ The Charge Nurse will ensure that the alert system is triggered in the EHR system when a new admission with high risk for falls and/or elopement/wandering behavior is identified. How the corrective action will be monitored to ensure that the deficient practice will not recur. ➢ The DON will review monthly incidents, analyze, and review specific interventions. ➢ The DON will revise/update the fall and elopement quality assurance program to ensure that potential problems will be identified and corrections will be established. ➢ The Charge Nurse and /or CNA supervisor will conduct daily rounds to ensure that door alarms are turned on. Correction Date: July 31, 2017	7/31/17 kp

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4 136	Continued From page 3 revealed that she and the staff were still "getting familiar" with the new Electronic Health Record (EHR). The DON also checked the medical record for a falls care plan but confirmed there wasn't one. The DON confirmed that Resident #28 should have a falls care plan based on her history of falling, which placed her at high risk. A review of the facility's policy titled, "Fall Prevention" on the morning of 5/18/17 at approximately 8:30 A.M. noted, "Implement a plan of care based on assessed risk factors." The facility failed to ensure the that Resident #28 received the necessary care and supervision to avoid additional falls/accidents. Additionally, the facility failed to ensure appropriate care and assistance was being provided based on the absence of a Falls care plan for Resident #28. 2) On 05/18/2017 at 7:41 AM MDS, which was filled out on 02/19/2017, review was completed and noted that resident (Res) #36 had a prior fall in the last 2-6 months prior to admission and an antidepressant and hypnotic was given during the last 7 days. Res #36 also has a diagnosis of [redacted] Dementia and Depression. Res #36 had an unwitnessed fall on 04/25/2017 in the dinning room resulting in abrasions to lower extremities from the fall from the wheelchair. On 05/18/2017 at 7:54 AM interviewed staff #28 who reviewed the resident's care plan. Staff #28 stated that there was an investigation done and that the resident "had a thing about going back to bed." Staff #28 explained that resident likes to go back to bed at that time and tries to get out of bed on their own. Staff #28 explained that staff try to encourage resident to stay in the dining room where there are more staff to monitor the resident	4 136		

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4 136	Continued From page 4 and prevent falls. When asked about activities in the afternoon staff #28 stated that Res #36 refuses, only reads the newspaper a little bit. When asked if resident has an alarm for his wheelchair staff stated they were not sure if resident had an alarm for their wheelchair. Review of Res #36 care plan states to "Review information in past falls and attempt to determine cause of falls. Record possible root causes. After remove any potential causes if possible." On 05/18/2017 interview with staff #60 was conducted to see if any changes were made to resident's care plan after the unwitnessed fall. Per staff #60 staff were told not to lock Res #36 wheelchair brakes since resident likes to roll self around. Staff #60 stated that when Res #36 was found on the ground it was noted that one wheel of the wheelchair was locked. This information was not seen in Res #36 care plan and staff #28 and #60 confirmed this information was missing. On 05/19/2017 at 11:12 AM interviewed Res #36 who was able to acknowledge that he had a recent fall and reported continued pain in his right leg which the medication nurse was providing PRN pain medication for as ordered. Res #36 stated "yes" when asked if he had tried to stand up from his wheelchair when he fell. Resident had healing scabs to right shin and left thigh. 3) On 05/18/2017 at 9:13 AM while doing a record review of resident (Res) #41's chart it was noted that resident had MDS significant change assessment done on 12/30/2016 and quarterly MDS done on 04/01/2017 which both showed that resident had wandering behavior that occurred 1 to 3 days. Review of resident's care plan for "elopement risk/wanderer, going out of the facility r/t dementia" had interventions listed such as	4 136		

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4 136	Continued From page 5 "Disguise exits: cover door knobs and handles, tape floor." While reviewing the resident's chart and looking at Res #41's room door it was noted that the closest exit, which is right next to the resident's bedroom door, was not disguised in any way, there was a stop sign on the door but the door knob handle was not covered and there was no tape on the floor. The door had an alarm on it but I was told by staff #60 and #28 that the alarm is "off during the day shift because the residents spend most of their time in the day room." On 05/18/2017 at 10:50 AM, while walking through the facility with staff #19, the exits in the day room were checked and the alarms on the doors were off at that time. When asked why the alarms were off staff #19 stated that there are more staff working during the day shift. Staff #19 was reminded that residents who wander, such as Res #41, was sitting in the day room. Staff was asked what would happen to the resident if staff were busy with other residents and not aware that the resident walked through the exit and staff #19 stated that the "resident could go to the street." Res #41 also has "Monitor location every 15 min. every shift. Document wandering behavior attempted diversional interventions in behavior log." as interventions. Record review and interview with staff #28 did not produce any documentation of interventions on a behavior log, no progress notes of wandering behavior or close monitoring, and no behavior log was found. The facility failed to provide an environment as free from accident hazards as is possible which may or has resulted in injury to the resident.	4 136		

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4 145	Continued From page 6	4 145	4 145 ACTIVITIES	
4 145	11-94.1-38(a) Activities (a) The facility must provide for an ongoing program of age-appropriate activities designed to meet the interests, physical, mental, and psychosocial well-being of each resident. This Statute is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide one resident (Resident #38) with reasonable accommodations based on individual resident needs. Findings include: Resident #38 understood what her call light was and she was able to follow instructions to press the button to call for assistance. An observation of Resident #38 on the morning of 5/17/17 at approximately 8:30 A.M. found her awake in bed. Resident #38's hands were disfigured and her fingers were crooked. Resident #38 was asked to press her call light. She attempted to press the call light but had difficulty because her fingers were crooked and her hands disfigured. Staff #5 came over to assist Resident #38 by holding onto the call light while the resident pressed the button. An interview of Staff #5 revealed the resident needed assistance with pressing her call light since her hands were disfigured with crooked fingers. An interview of the Administrator on the morning of 5/19/17 revealed that Resident #38, was indeed, able to use her call light. She further noted the facility should provide alternative devices/methods for residents to call the staff. The facility failed to ensure Resident #38 had an	4 145	<u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice.</u> ➢ On 05/29/17, the Assistant Administrator replaced the call button device with a call pad. This is to ensure that Resident #38 will be able to press and activate the facility's call system. ➢ The Interdisciplinary (ID) Team will update the resident's care plan. <u>How will you identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken.</u> ➢ All current and new residents having the same diagnosis with contractures on their hands will be potentially affected by the deficient practice. ➢ The facility will ensure to identify individuals in the risk group and will provide call pads to these residents. ➢ The Director of Nursing (DON) will provide in-service education to current and new staff about the deficient practice. <u>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</u> ➢ The DON will establish a protocol for call pads. This is to identify and provide for the needs of individuals in the risk group. ➢ The DON will provide education to all nursing staff on how to identify residents in the risk group. This will increase awareness and encourage the reporting of similar situations to ensure that the resident's needs are accommodated.	

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4 145	Continued From page 7 appropriate device which she was able to use in order to contact the staff.	4 145	➢ The MDS Coordinator will update/revise the resident's care plan as needed. How the corrective action will be monitored to ensure that the deficient practice will not recur. ➢ The DON will provide in-service education to all current and new staff. ➢ The ID Team will assess the identified risk group and update/ revise care plans quarterly. Correction Date: July 31, 2017	7/31/17 MR
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on observations, medical record review and staff interviews, the facility failed to develop care plans for 7 of 24 care plans reviewed in stage 2 of the QIS survey. Findings include: 1) Cross reference F323 for Resident #28. Resident #28 was admitted to the facility on 3/5/15 with a diagnosis of [redacted]. She was admitted to hospice services on 1/17/17. During the month of April 2017, Resident #28 experienced 2 unwitnessed falls (4/15/17 and 4/23/17). On the morning of 5/18/17, a review of the Minimum Data Set, MDS, with Assessment Reference Date, ARD, of 1/19/17 revealed the Care Area Assessment (CAA) Summary noted Resident #28 was triggered for Falls due to balance problems during transition, and noted that it was an existing problem. Resident #28's CAA summary further noted that Falls were addressed in her care plan.	4 174	4 174 INTERDISCIPLINARY CARE PROCESS What corrective action will be accomplished for those residents found to have been affected by the deficient practice. ➢ Resident #28 • The MDS Coordinator will review the MDS assessment and update/revise the care plan. • In addition, the Director of Nursing (DON) will review/revise fall protocols. ➢ Resident #39 – cross-reference F282. • The MDS Coordinator will update and revise the plan of care for Resident #39. Note that Resident	

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4 174	Continued From page 8 A medical record review for Resident #28 on the morning of 5/17/17 at approximately 10:00 A.M. found the facility did not develop a care plan for falls. An interview of the Director of Nursing on the morning of 5/18/17 at approximately 8:23 A.M. revealed the staff were "still getting familiar" with the new Electronic Health Record (EHR). The DON confirmed they did not have a current Falls care plan for Resident #28. On the morning of 5/18/17, a review of the facility's policy titled "Fall Prevention" noted that when a resident was identified as being a high risk for falls, the facility was responsible to, "Implement a plan of care based on assessed risk factors". The facility failed to implement a care plan for Falls despite knowledge that Resident #28 was high risk for falls. 2) Cross reference F282 for Resident #39. Chart review: 05/18/17 at 11:00 A.M. Resident #39 (Res#39) was admitted on 11/21/16 and seen for comprehensive nutritional assessment on 11/25/16. It was noted that Res #39 had lost 21 lbs over a 90 day period starting in 01/01/17. Res #39 is on a regular diet, finely chopped texture, regular consistency. Medical record review for Res #39 found that the facility did not develop a care plan for nutritional risks. Medical record review revealed a careplan for "The resident has a nutritional problem or potential nutritional problem, weight gain r/t fluid overload". Interview with Staff #28 on 5/18/17 at 11:11 A.M.	4 174	• #39 has a diagnosis of COPD with residual left sided weakness due to CVA. • The new Registered Dietician completed a comprehensive nutritional assessment on 06/11/17. How will you identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken. ➢ All current and new residents who are at risk for falls and weight loss are potentially affected by the deficient practice. ➢ The MDS Coordinator will utilize the task management in the new Electronic Health Record (EHR) program to ensure that care plans will be reviewed, revised and updated. ➢ The Charge Nurse will also update care plans within 72 hours of a fall incident. ➢ The Registered Dietician will provide nutritional assessments quarterly or as needed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	

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4 174	Continued From page 9 was done. Staff #28 stated that Res #39 verbalized that she wants to lose weight and and does not want to gain weight. It was further noted through chart review that Res #39 had not seen a dietician since December 12, 2016. Staff #28 stated that she was doing the assessments for nutrition. Res #39 chooses what she eats and she eats minimal amount. It was noted that Res #39 was on a dietary supplement of Glucerna 4 oz three times a day with meals. When asked about a careplan for nutritional risk for weight loss, Staff #28 stated "they did not have a registered dietician on board. Interview with Staff #60 on 5/19/2017 at 9:47 A.M. Staff #60 was advised regarding weight loss for Res #39 and there was no careplan to address weight loss. Staff #60 stated that they have not had a registered dietician on board and that they just hired a nutritionist last week. Staff #60 agreed that this needs to be followed up and she will look into it.	4 174	➢ The DON will provide annual in-service education on fall protocols and care plan processes to all license staff. ➢ The Registered Dietician will continue to provide nutritional assessments on residents, quarterly or as needed. How the corrective action will be monitored to ensure that the deficient practice will not recur. ➢ The DON will review/revise the care plan audit tool to establish a quality assurance program. Correction Date: July 31, 2017	7/31/17 MR
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 observation, chart review and staff interview the facility failed to revise 1 of 26 residents, of the Stage 2 Sample residents, Care Plan.	4 175	4 175 INTERDISCIPLINARY CARE PROCESS What corrective action will be accomplished for those residents found to have been affected by the deficient practice. ➢ The MDS Coordinator will review the MDS Assessment of Resident #36, update/revise the Morse Fall Scale Assessment, and update/revise his/her care plan. How will you identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken.	

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4 175	Continued From page 10 Findings include Cross Reference F323 for Resident #36 On 05/18/2017 at 7:41 AM review of MDS, which was filled out on 02/19/2017, was completed and noted that Resident (Res) #36 had a prior fall in the last 2-6 months prior to admission. An antidepressant and hypnotic was given during the last 7 days. Res #36. Res #36 has a diagnosis of [redacted] Dementia and Depression. Res #36 had an unwitnessed fall on 04/25/2017 in the dinning room resulting in abrasions to lower extremities from the fall from the wheelchair. On 05/18/2017 at 7:54 AM interviewed staff #28 who reviewed the resident's care plan. Staff #28 stated that there was an investigation done and that the resident "had a thing about going back to bed." Staff #28 explained that resident likes to go back to bed at that time and when then tries to go get out of bed on their own. Staff #28 explained that staff try to encourage resident to stay in the dining room where there are more staff to monitor the resident and prevent falls. When asked about activities in the afternoon staff #28 stated that Res #36 refuses, only reads the newspaper a little bit. When asked if resident has an alarm for his wheelchair staff stated they were not sure if resident had an alarm for their wheelchair. Review of Res #36 care plan states to "Review information in past falls and attempt to determine cause of falls. Record possible root causes. After remove any potential causes if possible." On 05/18/2017 interview with staff #60 was conducted to see if any changes were made to resident's care plan after the unwitnessed fall. Per staff #60 staff were told not to lock Res #36 wheelchair brakes since resident likes to roll self around. Staff #60 stated that when Res #36 was	4 175	➢ All current and new residents who are at high risk for falls are potentially affected by the deficient practice. ➢ The Charge Nurse and/or the MDS Coordinator will initiate the Morse Fall Scale Assessment. The MDS Coordinator will complete a plan of care based on the results. She will interview the resident and other nursing personnel to ensure that an individualized intervention is included in the resident plan of care. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. ➢ The Director of Nursing (DON) will review/revise the fall protocol. ➢ The MDS Coordinator will initiate a Morse Fall Scale Assessment and care plan within 72 hours of admission. ➢ The Charge Nurse will update care plan when a fall incident occurs. ➢ The Interdisciplinary (ID) Team will involve residents during quarterly care conferences and formulate an individualized intervention when possible. How the corrective action will be monitored to ensure that the deficient practice will not recur. ➢ The DON will develop a quality assurance program to audit the plan of care quarterly or as needed to ensure that the revision of the care plan is completed upon a fall incident. ➢ The DON will provide annual in-service education to all nursing staff with regards to fall protocols. Correction Date: July 31, 2017	7/31/17 RS

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4 175	Continued From page 11 found on the ground it was noted that one wheel of the wheelchair was locked. The information to not lock the brakes of the wheelchair was not seen in Res #36 care plan. Staff #28 and #60 confirmed this information was missing. The facility failed to revise a care plan for a resident which may result in injury to the resident.	4 175		
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 observations, medical record review and staff interviews, the facility failed to monitor and evaluate the use of psychotropic medications for 5 of 5 residents (Resident #28, Resident #12, Resident #34, Resident #18 and Resident #13) sampled for drug regimen review. Findings include: 1) Resident #28 was admitted to the facility on 3/5/15 with a diagnosis of [redacted] is a neurological disorder defined as a breakdown of nerve cells in the brain. A diagnosis of [redacted] means progressive deterioration in the person's cognitive function. Resident #28 was admitted to hospice on 1/17/17 with this diagnosis. Resident #28 was observed in the Activity Room	4 184	4 184 PHARMACEUTICAL SERVICES What corrective action will be accomplished for those residents found to have been affected by the deficient practice. ➢ MDS Coordinator will revise the care plan of Resident #28 to ensure that approaches will be specific and clear for the all Certified Nursing Assistants (CNAs). The Charge Nurse will indicate specific side effects to be monitored during each shift to ensure resident safety. ➢ The MDS Coordinator will review/revise the care plan of Resident #12. The Charge Nurse will revise/update the Behavior /Intervention Monthly Flow record to indicate the resident's specific target behavior and will monitor side effects. The Director of Nursing (DON) will	

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4 184	Continued From page 12 seated in a Geri chair on the morning of 5/16/17 at approximately 9:30 A.M. She appeared fidgety, in a reclined position with her body leaning toward the right side. On the morning of 5/17/17 at 8:00 A.M. Resident #28 was in the Activity Room seated in a Geri chair in front of the TV. She was alert, quiet, in a reclined position leaning to her right side. On the afternoon of 5/17/17 at approximately 1:45 P.M., Resident #28 was observed in bed, awake. She was quiet and responsive. A medical record review found Resident #28 had physician's orders for Seroquel (antipsychotic) 25mg orally daily; Mirtazapine (antidepressant) 7.5mg orally at bedtime; and Sertraline (antidepressant) HCl 25mg orally daily. The facility utilized "Behavior/Intervention Monthly Flow Records" for the use of the Seroquel and Mirtazapine. They did not have a flow record for Sertraline. A review of the flow records found the staff were documenting when the resident displayed behaviors such as "yelling/screaming"; "continuous crying out"; and "depressive mood as evidenced by poor oral intake". The staff marked the flow records when the resident displayed any behaviors. However, the corresponding interventions/outcomes or any side effects were blank/not documented. A care plan review for Resident #28 on the morning of 5/18/17 at approximately 10:00 A.M. found the care plan noted, "Assess for effects of psychotropic meds: dystonia, akithesia, akinesia, rigidity, tremors, etc." An interview of the Director of Nursing, DON, on the morning of 5/18/17 at approximately 10:15 A.M. found that the Certified Nurses Aides, CNAs, were not very likely to understand side effects listed such as dystonia, akithesia, etc. Additionally, Resident #28's	4 184	also update the Medical Director with the resident's behavior and a possible titration of psychotropic drug use. However, this particular resident exhibited psychotic behavior and was harmful to self and others when medication was titrated. ➢ The Charge Nurse will update the Behavior Monthly Flow Record for Resident #34 to indicate specific side effects that are listed on the care plan. ➢ The MDS Coordinator will review and update the care plan for Resident #18. Intervention to prevent/monitor for possible bleeding due to the use of Warfarin will be included. In addition, the Charge Nurse will utilize the new Electronic Health Record (EHR) system to ensure that all direct care staff are aware of specific or personalized approaches for individual residents. <u>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</u> ➢ All current and new residents that are receiving Warfarin and psychotropic drugs are	

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4 184	Continued From page 13 diagnosis of [redacted] may cause symptoms similar to the psychotropic medication side effects listed in her care plan. The facility failed to provide a clear, systematic approach for the management/oversight of the use of psychotropic drugs for Resident #28. 2) Resident #12 was admitted to the facility on 7/11/15 with diagnoses which included Diabetes Mellitus; Major Depressive Disorder; and Unspecified Dementia without behavioral disturbance. A review of physician's orders found Resident #12 was receiving the following medications: Seroquel (antipsychotic) 25mg orally daily; Seroquel 25mg orally every night; and Sertraline HCl (antidepressant) 50mg every night. On the morning of 5/16/17 at approximately 9:00 A.M., Resident #12 was seated in the Activities Room working on a puzzle. She smiled, interacted appropriately, and appeared pleasant. On the morning of 5/17/17 at approximately 8:30 A.M., Resident #12 was being assisted out of bed. She just had breakfast and was getting ready to go to Activities. Observation of Resident #12 on the afternoon of 5/17/17 found her in the Activities Room coloring. On the morning of 5/18/17 Resident #12 was observed participating in the morning exercise activity. A medical record review found Resident #12 had a care plan for the use antipsychotic medications with interventions which included, "Observe resident for any adverse side effects and document". The care plan did not describe the side effects to look for. The care plan further noted, "Monitor resident behavior and document	4 184	potentially affected by the deficient practice. ➢ The DON will provide in-service education to all license staff on the use of the EHR system using task management that will ensure that specific goals and/or approaches are listed in the resident daily care section. ➢ The DON will utilize a psychotropic medication log to monitor residents. ➢ The DON will review and revise the Behavior/Intervention Monthly Flow Record policy and procedures. ➢ The DON will conduct a monthly random check for the completion of the Behavior/Intervention Monthly Flow record. <u>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</u> ➢ The DON will provide an annual in-service training on the Policy and Procedure for Behavior/Intervention Monthly Flow Record to all license staff. ➢ The DON will utilize a log to monitor all residents on psychotropic medication to	

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4 184	Continued From page 14 at quarterly and as needed. Report any negative observations to physician." A review of the resident's "Behavior/Intervention Monthly Flow Record" found the resident was not demonstrating any behaviors. An interview of the DON on the morning of 5/18/17 revealed the care plan did not, but should have, included the adverse effects for the psychotropic medications Resident #12 was receiving. The DON reported that staff used the care plan as an outline for the care provided to the residents. The DON was asked how they determine a medication is necessary if they're not clearly monitoring and documenting it's necessity and adverse effects. The DON confirmed they need to be more specific about adverse effects and the necessity for medications by monitoring and evaluating their use. The facility failed to assess and evaluate the effectiveness and use of psychotropic medications for Resident #12. 3) On 05/18/2017 at 8:15 AM medical record reviewed and interviewed staff #28 who was able to show that Resident (Res) #34 had a care plan for depressed mood with interventions and side effects listed to monitor for. Resident is taking Celexa 20 mg po daily and behaviors "agitation walking out of facility" and "Depressive mood AEB poor po intake" are listed on the Behavior/Intervention Monthly Flow Record. On this form there are no side effects listed even though the resident's care plan has the following side effects listed to monitor for: lethargy, change in LOC, sleep problem (insomnia), weight changes. When asked staff #28 confirmed that the spaces on the monthly monitoring flowsheet were left empty but in the future would include	4 184	assess its use and possible reduction each quarter. ➢ The Interdisciplinary (ID) Team will conduct quarterly psychotropic medication assessments. ➢ The DON will conduct an annual in-service education to all license staff concerning the EHR system to ensure that all CNAs will have individualized approaches to resident daily care. ➢ The DON will review/revise the Policy and Procedure on Resident's Plan of Care. <u>How the corrective action will be monitored to ensure that the deficient practice will not recur.</u> ➢ The DON will conduct a quarterly quality assurance on the use and monitoring of psychotropic drugs. ➢ The DON will also conduct a quarterly quality assurance on the resident's plan of care. Correction Date: July 31, 2017	7/31/17

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4 184	Continued From page 15 side effects as listed in the care plan. 4) On 05/18/2017 at 9:42 AM medical record reviewed and interviewed staff #28 to discuss Resident (Res) #18 care plan for Warfarin. Res #18 is on Warfarin 3 mg every evening on Sunday, Tuesday, Thursday and Saturday and takes 2.5 mg every Monday, Wednesday and Friday for Atrial Fibrillation. Resident's care plan lists signs and symptoms "Monitor for easy bruising" and "Monitor for signs and symptoms of bleeding such as melena or black tarry stool, during defecation". On 5/18/2017 at 12:07 PM interviewed staff #11 who was caring for Res #18. When asked for what signs or symptoms that they have to report to the nurse staff stated "rash on the groin or legs". Staff #11 denied any bleeding with oral care or bruising noted that day with Res #18. Staff #11 was able to state that every shift the staff documents and reports any changes with resident's skin to the nurse but was not aware that resident is on a high risk for bleeding medication (Warfarin). 5) On 05/18/2017 at 10:24 AM medical record reviewed and interviewed staff #28 who was able to show that Resident (Res) #13 had a care plan in place for "mood problem r/t dementia with Paranoia" and "The resident has depression r/t Dementia". In Res #13 Care Plan for mood problem it states "Administer medications as ordered. Monitor/document for side effects and effectiveness." Interventions listed to monitor for were "Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/eating habits; change in sleep patterns; diminished ability to concentrate;	4 184		

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4 184	Continued From page 16 change in psychomotor skills." In resident's care plan for depression it states "Administer medications as ordered. Monitor/document for side effects and effectiveness." Interventions listed to monitor for were "Monitor/document/report PRN any s/sx of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health-related complaints, tearfulness. Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons." On Res #13 Behavior/Interventions Monthly Flow Record they did not have any side effects listed to monitor for Seroquel or Celexa as stated in the care plan. When asked staff #28 confirmed that the spaces on the monthly monitoring flowsheet were left empty but in the future would include side effects as listed in the care plan. The facility failed to provide adequate monitoring for high risk medications which may have an adverse effect on the resident.	4 184		
4 204	11-94.1-53(b)(1) Infection control (b) The facility shall have provisions for isolating residents with infectious diseases until appropriate transfers can be made. (1) The facility shall have a written policy that outlines proper isolation and infection control techniques and practices; This Statute is not met as evidenced by:	4 204	4 204 INFECTION CONTROL <u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice.</u> ➢ The Director of Nursing (DON) will review and revise handwashing protocols and will provide in-service education to all Certified	

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4 204	Continued From page 17 Based on observation and staff interview facility failed to ensure staff used proper hand-hygiene between residents during meal time; and, disinfected the blood glucose meter to reduce the spread of infections and prevent cross-contamination, used for 5 residents needing blood glucose checks. Findings include: 1) On 05/16/2017 at 11:31 AM during lunch observation, staff # 45 was seen assisting random resident and afterwards put the meal tray with the dirty dishes on the rolling rack and went back to assist another resident without performing hand hygiene between resident care. When questioned about this staff # 45 stated that she washed her hands before assisting first resident but was reminded that she went to help the second resident after putting away the dirty dishes and she stated that she had "forgotten" to use hand sanitizer or wash hands. 2) On 05/17/2017 at 1:52 PM staff # 47 was asked how she cleans the blood glucose meter that her facility uses to check the resident's blood glucose levels. Staff #47 stated that they use the "purple top wipes" and showed where the equipment was kept. Staff # 47 stated that staff #5 "helps me with this". Staff #5 told surveyor that the blood glucose meter was cleaned with "alcohol wipes right now" in between resident use "because the purple top wipes were expired." On 05/17/2017 at 2:00 PM interviewed staff #60 and asked how the staff disinfected the blood glucose meter at the facility. Staff #60 stated that she had discovered on 05/16/2017 the "purple top wipes" that they use to disinfect the meter with "was expired," with expiration date of 10/2016.	4 204	Nursing Assistants (CNAs) concerning the deficient practice. ➢ The DON will also perform random observations during meals to ensure that staff is following handwashing/hand hygiene protocols when serving and clearing dirty trays monthly, then quarterly. ➢ On 06/22/17, the DON provided in-service education to license staff concerning the new protocol for cleaning and using blood glucose meter. ➢ The DON will revise protocols regarding blood glucose meter use and cleaning. How will you identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken. ➢ All current and new residents are affected by the deficient practice when staff does not use proper hand hygiene while servicing multiple residents during meal service. ➢ All current and new residents with an order to use a blood glucose machine are affected by the deficient practice. ➢ The DON will review and revise handwashing and hand hygiene protocols during meal service. ➢ The DON will review and revise protocols for blood glucose meter cleaning. ➢ The DON will conduct random monthly checks on both hand hygiene and blood glucose meter cleaning.	

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4 204	Continued From page 18 She could not say how long these wipes were being used but the container that had been pulled was recently opened. Staff #60 pulled the expired wipes from the floor and ordered new wipes which staff # 22 picked-up that day. Staff #60 was able to confirm that PDI Sani-cloth wipes with bleach were obtained 05/17/2017 at 3:52 PM for use at the facility. From 05/17/2017 2:00 PM - 3:52 PM Staff # 60 brought out 3 new Assure Platinum meters to use for 3 of the 5 resident's receiving blood glucose checks and assigned them for one resident use only. Resident #19 and #12 are ordered blood glucose checks twice a day at 0630 and 1600, resident #37 and a random resident are ordered blood glucose checks Monday, Wednesday and Friday at 0530 and resident #39 is ordered blood glucose check on the 15th of the month at 0600. The facility failed to implement and monitor it's infection control program which may result in the spread of infections and cross-contamination between residents.	4 204	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. ➢ The DON will provide an annual in-service to all CNAs and license staff on the revised protocols on hand hygiene/handwashing and blood glucose meter cleaning. ➢ The DON will conduct a monthly/quarterly random observation on hand hygiene/ handwashing during meal service and blood glucose meter cleaning. How the corrective action will be monitored to ensure that the deficient practice will not recur. ➢ The DON will initiate audit tools for quality assurance that will ensure that protocols for hand hygiene/handwashing during meal service and for cleaning the blood glucose meter are being followed. Correction date: July 31, 2017	7/31/17
4 281	11-94.1-65(e)(8) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (8) Each resident shall be provided with: (A) A separate bed of proper size and height for the convenience of the resident and that permits an individual in a wheelchair to get in and out of bed unassisted; (B) A comfortable mattress with impermeable mattress cover, and a pillow with an impermeable cover; (C) Sufficient clean bed linen and	4 281	4 281 CONSTRUCTION REQUIREMENTS What corrective action will be accomplished for those residents found to have been affected by the deficient practice. ➢ The Assistant Administrator will conduct a monthly call light system check. This is to ensure that all call lights will	

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4 281	Continued From page 19 blankets to meet the resident's needs; (D) Appropriate furniture, cabinets, and closets, accessible to and meeting individual resident's needs. Locked containers shall be available upon resident's request; and (E) An effective signal call system at the resident's bedside. This Statute is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure the Resident Call System was working properly. Findings include: The facility's Resident Call System notified the staff via two methods: Four LED boards located in the hallways throughout the facility; and Pagers which staff carried in their pockets. The call system was noted to have a delay from the time the call light was activated to when the LED boards lit up and the staff pagers rang. On the morning of 5/19/17 at approximately 8:10 A.M., surveyor pressed the call lights, one after the other, for 12A, 12B, 12C, and 12D. The LED display and pager ring for 12A displayed at 8:12 A.M. (2 minutes later); 12B displayed at 8:14 A.M. (4 minutes later); 12C displayed at 8:15 A.M. (5 minutes later); and 12D displayed at 8:20 A.M. (10 minutes later). At 8:15 A.M., surveyor pressed the call lights, one after the other, for 13A, 13B, 13C, and 13D. The LED display and pager ring for 13A displayed at 8:17 A.M. (2 minutes later); 13B displayed at 8:18 A.M. (3 minutes later); 13C displayed at 8:25 A.M. (10	4 281	function properly when activated simultaneously. ➢ The Assistant Administrator will print a monthly report to monitor staff response times and provide it to the Director of Nursing (DON). ➢ The Charge Nurse and/or Certified Nursing Assistant (CNA) supervisor will ensure that CNAs carry pagers to alert them when a resident requests assistance. ➢ The volume for the alarms has been adjusted to ensure that pagers are at a tone that will not agitate the residents. ➢ The CNA supervisor and/or Charge Nurse, during their daily rounds, will ensure that bed alarms are activated. How will you identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken. ➢ All current residents are affected by the deficient practice and corrections above will be implemented. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	

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4 281	Continued From page 20 minutes later); and 13D displayed at 8:26 A.M (11 minutes later). The time from when the call light was pressed to when the staff were notified took up to 11 minutes. In addition to the delayed notification time, the residents still needed to wait for the staff to respond to the calls. A review of the call response time (after the staff received notice) during the week of survey found that the response time varied. On 5/17/17 at 4:33 A.M., Room 2 called and waited 24 minutes and 32 seconds. On 5/17/17 at 12:23 A.M., Room 10D called and waited 21 minutes and 3 seconds. On 5/16/17 at 6:00 A.M., Room 5 called and waited 23 minutes and 11 seconds. On 5/15/17 at 8:16 P.M., Room 17A called and waited 28 minutes and 29 seconds. The response times were in addition to the amount of time it took for the call to be registered to the LED board and staff pagers. An interview of the Assistant Administrator on the morning of 5/19/17 at approximately 7:56 A.M. revealed the manufacturer for the call light system was based in Iowa. The Assistant Administrator noted that the person who did the installation of the call light system informed the facility they needed an additional "repeater" to boos the response of calls. The Assistance Administrator stated he had not yet purchased the repeater. Surveyor asked the Assistant Administrator to provide a report for 5/16-5/19/17 of the call response times. The Assistant Administrator noted that on 5/16/17 he cleared one of the message options which should improve the notification time. He was asked whether he tested the system after making this change. He reported that he tested each room, one at a time. He did not activate the call lights simultaneously but rather waited for each call to register on the display/page before moving to the	4 281	➢ The Charge Nurse will ensure all CNAs will carry their pagers. ➢ The Charge Nurse and/or CNA supervisor will conduct daily rounds to ensure that all bed alarms are activated. ➢ The Assistant Administrator will conduct a monthly call light system check to ensure proper function of the system. <u>How the corrective action will be monitored to ensure that the deficient practice will not recur.</u> ➢ A quality assurance program will be created by the Director of Nursing to ensure quarterly monitoring and identification of potential problems. Correction Date: July 31, 2017	7/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	05/19/2017

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4 281	Continued From page 21 next room. He was then asked whether they regularly test the resident call system to ensure it's functioning to which he replied no. Additionally, the Assistant Administrator noted he doesn't monitor the staff's response time to the call lights. On 5/19/17 at approximately 9:21 A.M., the Administrator reported they contacted the resident call system manufacturer earlier that morning and was informed that the system could only accommodate 2 or 3 calls at the same time. The Administrator was unaware of this and stated she would immediately correct the problem. On 5/19/17 at approximately 9:54 A.M. the Administrator and Assistant Administrator stated they made changes to the resident call system. The Assistant Administrator noted he deleted several layers of data retrieval/notification steps. After deleting those layers, the Assistant Administrator tested the call system by pushing 10 call lights simultaneously. He reported the display/pagers were activated after one minute and 36 seconds. The issue improved as the Surveyor was able to verify the information by again testing the call system. 2) 05/16/2017 at 9:41 A.M. During Stage I of the survey, this surveyor pushed Resident #47's (Res #47) call light; however, Res #47 not in bed. Alert of call button seen on LED display. Because no one responded after several minutes, this surveyor spoke to Staff #45. who was assisting another resident in the bathroom. Interview with Staff #45 who stated that there is also a bed alarm that alerts to the nurses station but it was off. The LED display does not sound an alert and the CNA was assisting another res in the	4 281		

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4 281	Continued From page 22 bathroom, so she would not know if Res #47 had called. 05/16/2017 at 1:32 P.M. a revisit to Res #47's room revealed Res #47 to be confused and attempting to get out of bed. Retrieved Staff #45 and asked about her call bell as call bell is hanging at the side of the bed and her Sensatec Bed alarm did not sound. Staff #45 stated that the Sensatec bed alarm was off. Staff #45 stated that the Sensatec bed alarm was off because the resident's don't like the sound. On further questioning, Staff #45 stated that Res #47 is confused and does not know what her call bell is. At this time, surveyor asked Staff #45 to test her pager with the call bell. Staff #45 stated "they turn off". Staff #45 confirmed that resident could not use her call bell because of confusion and that her Sensatec bed alarm was turned off. 05/18/2017 9:44 A.M. Interview with Staff #60. Staff #60 stated, the pager is a little too noisy and it's linked to the call bell. The residents complained they dont like the pager because it startles them. When they press the call light, there are three flashers, one in the hall, one in dining room that faces the nursing station. The three Led display monitors and pager makes a sound. Staff #60 stated that we have aides for each side, A,B,C and D who are accountable for the LED displays. If B, C and A are busy, we have the Rehab aide and Tx aide. The bed alarm wont trigger the LED displays, so for Staff #45, the Sensatec bed alarm should be on. Staff #60 was told by this surveyor of her observation regarding Res #47's back-up system being turned off. Staff #60 stated "back up system should not have been turned off". The facility failed to ensure an efficient/effective	4 281		

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4 281	Continued From page 23 resident call system.	4 281		
4 283	11-94.1-65(g)(1)(2) Construction requirements (g) The facility shall ensure that floors and walls are maintained as follows: (1) Floor coverings shall be of slip resistant material that does not retain odors and is flush at doorways; and (2) Walls, floors, and ceilings of rooms used by residents shall be made of materials that shall permit washing, cleaning, and painting. This Statute is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a sanitary, comfortable interior. Findings include: A tour of the facility on the morning of 5/17/17 found the facility had odors and required maintenance/repair. On 5/17/17 at approximately 11:00 A.M., an observation of the toilet room between rooms 10 and 11 found old/chipped paint and an old pest bait station stuck to the wall in the right corner, close to the ceiling. Observation of the toilet room between rooms 12 and 13 found a strong odor of urine, old/chipped paint and an old pest bait station stuck to the wall in the left corner, close to the ceiling. On the morning of 5/19/17 at approximately 8:30 A.M., an interview of Staff #3 revealed the facility had plans to renovate the facility. Staff #3 confirmed the facility needed repairs and upkeep	4 283	4283 CONSTRUCTION REQUIREMENTS What corrective action will be accomplished for those residents found to have been affected by the deficient practice. ➢ The Maintenance Supervisor will repaint the bathroom walls located between rooms 10 & 11 and 12 & 13. ➢ The Housekeeping Supervisor will conduct daily rounds to ensure that the resident's bathrooms are clean and sanitary, having a comfortable environment for the resident. How will you identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken. ➢ All current and new residents are potentially affected by the deficient practice. ➢ The Housekeeping Supervisor will conduct daily rounds to ensure a sanitary environment in the facility.	

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4 283	Continued From page 24 and the plans were going forward. The facility failed to maintain a sanitary, orderly and comfortable environment for the residents.	4 283	<u>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</u> ➢ Monthly rounds will be conducted by the head of the maintenance department to identify areas needing repair. <u>How the corrective action will be monitored to ensure that the deficient practice will not recur.</u> ➢ The head of the maintenance will create a preventative maintenance log that will be checked monthly. ➢ A quality assurance program will be created by the Director of Nursing to monitor environmental sanitation in the facility and to identify potential problems. Correction Date: July 31, 2017	7/31/17 JK