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
	125040	A. BUILDING: ______ B. WING ______	06/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET HILO, HI 96720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	11-94.1 Initial Comments A re-licensing survey was conducted from 06/13-16/2017. The facility was licensed for 252 beds. The census of 226 residents was proivided at the entrance conference. The facility was cited for resident abuse and neglect on this survey.	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, the facility failed to ensure that care was provided in a manner that promoted, maintained and/or enhanced a resident's quality of life, and recognized each resident's individuality, for 4 of 32 residents (R#78, #286, #143, #145) on the survey sample. Findings include: 1) During observation of the dining on 06/13/2017, two residents were observed being fed simultaneously by Staff #123 in the 1st floor	4 115	RECEIVED 2017 AUG -7 A 10:40 STATE OF HAWAII DOH-OHCA MEDICARE	

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark Moran TITLE: Executive Director (X6) DATE: 8/4/17

Emailed to ... 8/4/17

Hawaii Dept. of Health, Office of Health Care Assuranc

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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4 115	Continued From page 1	4 115		

North unit dining room. Staff #123 was seated between the two residents and would feed one resident one or two mouthfuls of food and then feed the other resident a mouthful and continued to do so for the entire meal. Staff #123 used the same hand to feed both residents.

Staff #123 did not provide both residents with any dignity or individualized care by feeding them in this manner.

2) On 6/13/17 at 11:25 P.M. observed two staff members preparing to deliver lunch trays. One staff member was heard stating that he/she needs to wash his/her hands. The two staff members announced themselves and entered Room 203 and washed their hands at the sink. Observed R#78 was seated in the room during this time. While washing their hands, the staff members continued to have a conversation which did not include Resident #78. On 6/14/17 at 11:50 A.M. an interview was done with Staff Member #225 to inquire whether the unit has a hand washing sink at the nurse's station to wash their hands. The staff member confirmed there is a sink at the nurse's station, the sink is labeled "Eyewash Station" and has soap and paper towels dispenser to perform hand washing.

3) Observation on 6/14/17 at 8:27 A.M. Staff #241 was at the medication cart, and queried staff member whether the resident sitting by the doorway was R#286. The staff member confirmed it was R#286 and warned the surveyor not to be concerned as the resident yells. The staff member commented that R#286 is a "squeaker".

4) On 6/15/17 at 8:04 A.M. observed Staff #265 assist R#143 with breakfast. The staff member

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4 115	Continued From page 2 assisted the resident to place a large napkin on the resident's lap and chest, remarking to the resident that the napkin would be placed so "you don't make a mess". A record review done on 6/15/17 at 10:45 A.M. found an annual Minimum Data Set with an assessment reference date of 3/27/17 documenting R#143 requires extensive assistance for eating with one person physical assist. 5) On 6/16/17 at 10:07 A.M. while standing at the nurse's station, Staff #241 was heard stating in a loud voice, saying to Staff#225 that R#145 took off his/her brace and threw it down and "the guy" picked it up. Staff#241 was at the medication cart outside of Room 212. As Staff #225 approached the cart, Staff #241 spoke in a softer voice. During this time, there were two residents seated in the hall between Rooms 210 and 212 that overheard the staff members conversation.	4 115		
4 125	11-94.1-27(14) 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: (14)The right to personal privacy and confidentiality of personal and clinical records; This Statute is not met as evidenced by: Based on family and roommate interviews, the	4 125		

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4 125	Continued From page 3 facility failed to maintain confidential personal and clinical information for 1 of 32 residents (R#50) sampled for the survey. Findings included: On 06/13/2017 at 01:43 PM during Stage 1 of the survey, a family interview was conducted for R#50. When the family representative was queried whether the facility staff informed the family member about the resident's condition(s) privately, the reply was, "No." According to the family member, on several occasions the nursing staff have reported the residents blood pressure with the roommate in bed and able to hear everything being said about R#50. On 06/16/2017 at 8:33 AM went to observe R#50 and the room shared with the roommate. The resident's bed was empty and the roommate was sitting in a wheel chair watching TV with hrer breakfast tray on an overbed table. The roommate stated that R#50 went to the eye doctor and will be back later. Queried roommate how she knew this information. Roommate stated that their was room so small, and able to hear everything told to R#50 when staff come in to provide care. The facility staff did not ensure R#50's right to privacy that included privacy of personal and clinical information from the roommate.	4 125		
4 130	11-94.1-29(a) Resident abuse, neglect, and misappropriation (a) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident	4 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 06/16/2017

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4 130	Continued From page 4 property. This Statute is not met as evidenced by: Based on observation, medical record review (MRR) and staff interviews, the facility failed to ensure that female residents were not subjected to sexual harrasment from a male resident in the same locked special care unit. Findings include: Interviewed Staff #136 on 6/13/17 who stated that R#249 continues to follow the female resident and continues to try to touch and be close. "A couple of the female residents are disturbed by the resident's behavior. When sitting in their chairs and R#249 approaches them, they will fold their arms across their bodies and not make eye contact. They also try to move away but he follows. Staff #136 further stated that two female residents in particular do not like anyone in their space. One female resident is easily agitated with anyone and everyone and R#249 needs constant redirection. This is a dementia unit. Moods change as soon as you drop a pen on the floor. Some residents like their space. It is not black or white." Medical record review on 6/15:17 at 8:32 A.M. on R#249 was conducted, and it was noted that the resident was admitted to the facility in 10/2016 for custodial care and behavioral management. R#249 was admitted with a history of [redacted] [redacted], aggressive behaviors towards males and liked touching females. Pharmacy along with the MD were adjusting medications to control behaviors in the months of March and April	4 130		

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4 130	Continued From page 5 In March, gradual dose reduction (GDR) was looked at by the behavior enhancement committee and GDR was attempted. R#249 did have a dose reduction of his Risperdal in March from 1 mg Am/1 mg midday/2mg at night to 1 mg three times a day. Review of Psychopharm Committee Minutes dated 5/11/17 discussed R#249 and suggested increasing citalopram, adding Tylenol, monitor 3-4 weeks behavior per MD. It stated that R#249 continues to approach female residents personal space. Staff to redirect and effective. A note written by MD on 5/17/17 noted that staff had noticed increase in behavioral disturbances since citalopram and Risperdal were reduced. Record review for the months of May and June revealed R#249 exhibited aggressive and desire to touch females on the following dates: 5/20/17 - Hanging around females, trying to touch the females. 5/21/17 - Trying to touch the females 5/24/17 - Trying to touch females, touching hair, trying to kiss. 5/25/17 - Trying to touch females. 5/26/17 - Trying to touch females.. On 6/2/17 - R#249 Risperdal was increased to 1.5 mg at lunch. 6/18/17 - Trying to touch females. 6/19/17 - eating others food if not supervised and trying to touch females. 6/10/17 - Trying to touch females. 6/12/17 - R#249 punch a resident in stomach 6/14/17 - R#249 grabbed a females buttocks. Psychopharm Committee Minutes dated 6/8/17 were reviewed. Documentation for R#249 per the minutes stated that R#249 is hyperactive, sexual	4 130		

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behaviors (touching). The team was recommending to continue medication Provera along with interventions. Redirect resident when approaching female residents personal spaces, provide snack. Have staff ask resident if he needs assist with something.

Interviewed Staff #136 on 6/15/17 at 10:18 A.M. to clarify R#249's behaviors, and staff member related that R#249 "gets jealous. "
For example, one of the incidents that occurred was of the female unit manager talking with another male resident in the hall and R#249 came walking by and without provocation, hit the other male resident in the stomach, out of jealousy as he was talking to the female unit manager. R#249 seemed to get aggravated and jealous. Staff#139 further stated that R#249 likes to hang around woman and protect them, however, the resident has been getting better with medications.

Interviewed Staff #167 regarding R#249 and asked what the goal was for R#249. Staff #167 stated our goal is for R#249 to be able to wander about the unit safely to prevent and decrease incidents of any altercations because of his impulsiveness. When asked if there is a care plan for R#249, Staff #167 stated "I don't see a specific care plan for the touchy feely with the females. They should be charting on the behavior monitor sheet.

A review of the "Behavior Monitoring Form" demonstrated the behaviors documented in the progress notes of the records did not collaborate with the care plan. This form lists codes for behavior, location code, intervention code and resident response. The form also had not been updated since May 10, 2017 although the

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4 130	Continued From page 7 recommendation to monitor for 3-4 weeks per MD in psychopharm committee minutes was suggested on May 11, 2017. This was pointed out to a staff member who did not have any answer except "yea, we're supposed to document on that form". The female residents in the same secured unit as R#249 were subjected to unwelcome touching and attention from this male resident. The facility failed to provide care and have safe-guards in place to ensure these female residents were not subjected to sexual harrasment and inappropriate sexual behaviors. The facility staff stated that the female residents have dementia and their cognitive deficits make them unaware if anything untoward happened. The facility practice was harmful to these female resident's who should have been safe from inappropriate sexual behaviors towards them and ensured their psychosocial well-being.	4 130		
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;	4 149		

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Continued From page 8

(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.

This Statute is not met as evidenced by:
Based on interviews and medical record reviews, the facility failed to establish an agreed upon coordinated plan of care with outside providers for 2 of 32 residents on the Stage 2 resident sample list, (R#313 dialysis and R#262 hospice). The facility failed to ensure that both residents obtained optimal improvement or did not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology.

Findings include:
1) On 06/14/2017 at 2:30 PM interviewed R#313 and spouse at bedside. The resident received 3.5 hours of dialysis treatment on Monday, Wednesday, and Friday at 5:00 AM and was transported to the dialysis provider.
The resident described that facility staff would take weight before left the facility and that the dialysis center staff re-weighed before & after dialysis treatment. The resident described fluid restriction as 1/2 cup between meals and that would drink soda once in awhile. The resident also stated that facility staff checked the fistula site daily.

According to R#313 and spouse, resident admitted to facility for physical therapy after falling

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at home. The resident was diagnosed with fracture of L4 and now leg muscle weakness more on the left (L) than right (R) side. The resident hoped to go home in a couple of weeks, "As long as able to stand enough to go into wheelchair."

The R#313 also had a PleurX Catheter, the spouse provided the card description, "this is a PleurX Catheter which is used for drainage of recurrent pleural effusions or ascites. It has a unique valve that can only be accessed with a special access tip. See back for emergency instruction." According to the spouse, a specialist placed the catheter after the resident was hospitalized after being seen in ED for shortness of breath (SOB), due to pleural effusion. The resident no longer needs oxygen since the catheter is drained every 3 days by the spouse. According to the spouse, who comes in to drain the PleurX with the drainage kit that is stored in the resident's room, the staff never asked about the PleurX catheter.

On 06/14/2017 at 2:58 PM, a MRR on R#313 was done. The resident's diagnosis list included: wedge compression fracture of 4th lumbar vertebra, subsequent encounter for fracture with routine healing; other chronic post procedural pain; difficulty in walking, not elsewhere classified; muscle weakness; ESRD; nausea with vomiting; peripheral vascular disease, unspecified; Type2 DM w/o complications; essential primary hypertension; chronic atrial fibrillation; heart failure; and, pleural effusion.

The physician orders (PO) included: "Check Thrill & bruit Q shift +present/- absent (notify MD); Hemodialysis 3x/wk on MWF & Prn Holidays at Hilo Liberty Dialysis; Lasix 80 mg tab PO twice

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daily for CKD Generic: Furosemide..."

On 06/15/2017 at 7:59 AM the MRR noted communication between the facility and dialysis provider was documented on a "PRE/POST DIALYSIS COMMUNICATION" form. Started with the most recent Dialysis Communication form and found missing documentation on:
6/14/17 - Dialysis Center no assessment of Condition of access/site and Bruit
6/12/17 - Incomplete, dialysis center had vital signs (VS) but did not assess condition of access/site;
post dialysis by facility had no VS or weight (wt) of resident, but did assess condition of access site and bruit.
6/2/17 - No documentation by Dialysis Center
5/24/17 - No post-dialysis wt by Dialysis Center
5/17/17 - Pre-dialysis wt 147.4; Dialysis Center post-dialysis (66.3 kg) = 146.166 lbs; SNF ,Post-dialysis wt 157.6 lbs.
Queried Staff#225 regarding wt discrepancy between the Dialysis Center and facility. Staff#225 looked in R#313's electronic medical record (EMR) and could not find information and called Staff#57 for resident's wts and unable to find. The EMR progress notes documented "66.3 kg" upon return, which was also noted on the post dialysis form by the Dialysis Center. Queried Staff#225 if 10 lbs over pre-dialysis treatment would be alarming to staff and she felt that it should have been but could not find any documentation that staff called the MD.

On 06/15/2017 at 9:46 AM interviewed Staff#71 and was informed by him that a care plan (CP) meeting was to be held on this date with R#313 and spouse. The CP meeting was to discuss discharge planning and Staff#71 planned to ask spouse if Dialysis Center providing Epogen

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injections because typically done at dialysis. Staff#71 was concerned about edema and prescribed a higher dose of Lasix for R#313 because the resident was anuric and felt not enough fluid was being removed at the Dialysis Center. Queried Staff#71, if prescribed Lasix done in collaboration with resident's nephrologist, and he replied, that in a similar resident it was successful. Queried if R#313 had the same nephrologist and Staff#71 stated that it was a different nephrologist, but "I also did this at (acute health care agency) and am comfortable with the outcome." Staff#71 further stated that R#313 was more complex medically and that spouse still wants to take R#313 home, and Staff#71 relied on spouse for information because "akamai" about R#313's health care.

On 06/15/2017 at 10:38 AM met with Staff#71 and Staff#57, as Staff#71 wanted to clarify that R#313's labs were reviewed and repeated due to concerns about resident's increasing confusion during the evenings. Staff#71 also stated that R#313 on dialysis for several years and labs are actually stable. Also, Staff#57 monitors resident with renal dietitian and that
R#313 being provided epogen and other renal medications at Dialysis Center. Discussed resident's post-dialysis wt on 5/17/17 being 10 lbs. over pre-dialysis wt and whether MD was notified. Staff#71 looked in resident's EMR for any documentation and only found that R#313's Wt. of 145 lbs on 05/19/17.

Staff#71 further reiterated that he ordered Lasix based on how R#313 looked edematous and felt that not enough fluid being pulled off. When queried if there was any collaboration with the resident's nephrologist and Staff#71 stated that this particular nephrologist would contact him

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only regarding behaviors but cannot tell nephrologist what to do so diuretic ordered on his part, as R#313's nephrologist was not receptive to other Dr's suggestions.
Queried whether staff should have alerted Staff#71 when R#313 returned from dialysis 10 lbs more than pre-dialysis Wt. Staff#71 stated that staff should have let him know and cannot speak for staff on why they didn't. Staff#71 further stated that R#313's confusion at night probably due to use of oxycodone for pain and had to increase gabapentin for sciatica pain.

On 06/15/2017 at 11:09 AM interviewed Staff#225 and asked for R#313's intake/output (I/O) sheets. Staff#225 could not provide I/O sheets and later stated that there were no physician orders for fluid restriction. Went to ask Staff#71 whether staff should be monitoring fluid intake/output since resident receiving dialysis and prescribed Lasix for edema. According to Staff#71, the facility believes in liberalizing resident's diets for quality of life so I/O monitoring was not being done for
R#313.

On 06/15/2017 at 11:14 AM interviewed Staff#57 who confirmed that R#313 was not on fluid restrictions. According to Staff#57 the Dialysis center did not order fluid restrictions for the resident and Staff#57 printed out the dietary progress notes dated 04/18/17, "Addendum: MD stated no need to start fluid restircition at this time. Will monitor weight trend for now."

On 06/15/2017 at 1:13 PM interviewed Staff#57 and she provided R#313's estimated dry weight (EDW) to be 148.5 lbs. Staff#57 stated that she communicated monthly with the Dialysis Center's RD and after speaking with the renal RD today,

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4 149	Continued From page 13 she found out that the resident's fluid gains between treatments have been acceptable. 2) Cross Referenced to F279 On 06/14/2017 at 3:00 PM, MRR on R#262, found that there was no hospice care plan (CP). The Physician referral order to hospice was dated 01/18/2017, and the hospice physician signed the hospice certification on 01/23/2017. On 06/15/2017 at 9:422 AM, interviewed Staff #150 about the hospice CP for R#262, and she stated that they were currently formulating a hospice CP for the resident. The MDS 3.0 dated 01/23/2017 for significant change on R#262, had the response "yes" to question "J1400 anticipated life expectancy of less than six months." The facility staff did not collaborate with the dialysis center to ensure that R#313 obtained optimal improvement within the limits of his/her renal disease diagnosis; and, R#262 had been on hospice care since January and the facility had not developed and implemented a hospice CP to ensure highest possible level of well-being for end-of-life care.	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,	4 159		

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4 159	Continued From page 14 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 and interview the facility failed to store food under sanitary conditions. Findings include: 2) During a tour of the kitchen on 06/13/2017, it was observed in the pantry 4 large containers, approximately 5 gallon (1 that contained flour, 1 that contained sugar and 2 that contained rice). These containers had no labeling on them to say when the ingredients had been placed in them nor any expire date for them. Interview with Staff # 242 confirmed that these containers had no labeling with dates to say when ingredients were placed and expire dates. In the pantry there was also an opened box of tomato ketchup packets. The box had on the outside a date marked 06/01 with no year. This date did not state if if was the opening date or the expire date. The labeling on the box and lack of labeling on the containers did not ensure storage of foods under sanitary conditions.	4 159		
4 173	11-94.1-43(a) Interdisciplinary care process (a) A comprehensive assessment shall be completed for each resident by an interdisciplinary team at least annually and updated as appropriate, based on the resident's condition.	4 173		

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This Statute is not met as evidenced by:
Based on record review and interview with staff members, the facility failed to ensure 3 residents (R#249, # 286, #262,) of 16 sampled residents of the 32 residents in Stage 2 developed a comprehensive person-centered care plan for each resident.

Findings include:

Medical record review on 6/15:17 at 8:32 A.M. on R#249 was conducted, and it was noted that the resident was admitted to the facility in 10/2016 for custodial care and behavioral management. R#249 was admitted with a history of [redacted] [redacted], aggressive behaviors towards males and liked touching females. Pharmacy along with the MD were adjusting medications to control behaviors in the months of March and April

In March, gradual dose reduction (GDR) was looked at by the behavior enhancement committee and GDR was attempted. R#249 did have a dose reduction of his Risperdal in March from 1 mg Am/1 mg midday/2mg at night to 1 mg three times a day.

Review of Psychopharm Committee Minutes dated 5/11/17 discussed R#249 and suggested increasing citalopram, adding Tylenol, monitor 3-4 weeks behavior per MD. It stated that R#249 continues to approach female residents personal space. Staff to redirect and effective.

A note written by MD on 5/17/17 noted that staff had noticed increase in behavioral disturbances since citalopram and Risperdal were reduced. Record review for the months of May and June revealed R#249 exhibited aggressive and desire

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to touch females on the following dates:
5/20/17 - Hanging around females, trying to touch the females.
5/21/17 - Trying to touch the females
5/24/17 - Trying to touch females, touching hair, trying to kiss.
5/25/17 - Trying to touch females.
5/26/17 - Trying to touch females..
On 6/2/17 - R#249 Risperdal was increased to 1.5 mg at lunch.
6/18/17 - Trying to touch females.
6/19/17 - eating others food if not supervised and trying to touch females.
6/10/17 - Trying to touch females.
6/12/17 - R#249 punch a resident in stomach
6/14/17 - R#249 grabbed a females buttocks.

Psychopharm Committee Minutes dated 6/8/17 were reviewed. Documentation for R#249 per the minutes stated that R#249 is hyperactive, sexual behaviors (touching). The team was recommending to continue medication Provera along with interventions. Redirect resident when approaching female residents personal spaces, provide snack. Have staff ask resident if he needs assist with something.

Interviewed Staff #167 regarding R#249 and asked what the goal was for R#249. Staff #167 stated our goal is for R#249 to be able to wander about the unit safely to prevent and decrease incidents of any altercations because of his impulsiveness. When asked if there is a care plan for R#249, Staff #167 stated "I don't see a specific care plan for the touchy feely with the females. They should be charting on the behavior monitor sheet.

A review of the "Behavior Monitoring Form" demonstrated the behaviors documented in the

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4 173	Continued From page 17 progress notes of the records did not collaborate with the care plan. This form lists codes for behavior, location code, intervention code and resident response. The form also had not been updated since May 10, 2017 although the recommendation to monitor for 3-4 weeks per MD in psychopharm committee minutes was suggested on May 11, 2017. This was pointed out to a staff member who did not have any answer except "yea, we're supposed to document on that form". 2) A record review for Resident #286 was done on the afternoon of 6/14/17 and the morning of 6/15/17. A review of the quarterly Minimum Data Set (MDS) with assessment reference date of 5/12/17 documents Resident #286 has a moderate visual impairment. A review of the resident's plan of care provided by the facility on 6/14/17 at 3:00 P.M. found no documentation of a care plan for Resident #286 to identify care/approaches to address the resident's visual impairment. On 6/15/17 at 8:30 A.M. an interview and concurrent record review was done with the MDS Coordinators. A review of the electronic medical record and hard copy of the resident's care plan found no documentation of a care plan to address the resident's moderate visual impairment. Staff Member #84 reported vision was not triggered on the initial assessment in February 2017; therefore, a care plan was not developed. Inquired whether following the quarterly assessment if a care plan is indicated for this resident. Staff Member #84 confirmed a care plan to address the resident's impaired vision is indicated. 3) On 06/14/2017 at 3:00 PM , MRR for R#262	4 173		

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4 173	Continued From page 18 was done. No care plan for hospice care was found in his medical record. Physician referral order to hospice was dated 01/18/2017, and hospice physician signed the hospice certification on 01/23/2017. On 06/15/2017 at 9:422 AM, Staff # 150 was interviewed about the care plan for hospice for resident. She stated It hadn't been done and they were currently formulating a care plan for his hospice care. Significant change MDS dated 01/23/2017 had the response yes to question J1400 asking if resident had anticipated life expectancy of less than six months. The resident had been on hospice care since January and the facility had not developed and implemented a care plan for hospice services.	4 173		
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 record review and interview with staff members, the facility failed to ensure a care plan was revised for 1 of 16 sampled residents (R#286) of 32 residents sampled. Findings include: Cross Reference to F274 and F310. Record review was done on the afternoon of 6/14/17 and morning of 6/15/17. A review of the initial Minimum Data Set (MDS) with an	4 175		

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4 175	Continued From page 19 assessment reference date (ARD) of 2/15/17 with the most recent quarterly MDS with an ARD of 5/12/17, R#286 was assessed to have a decline in three areas (bed mobility, dressing and eating) of activities of daily living. A review of the resident's plan of care provided by the facility on 6/14/17 noted a care plan was developed for activities of daily living. The initial target date was 5/13/17 and later changed to 8/14/17. The goal was for the resident to continue to participate as able with daily ADLs with assistance of staff. There is no revision to the care plan based on an assessment (identifying contributing factors) to reflect the resident's decline in ADLs as assessed on 5/12/17. On 6/15/17 at 8:30 A.M. an interview and concurrent record review was done with the MDS Coordinators. Inquired whether R #286's care plan was updated following the ADL decline. Staff#84 reported there was no update to the resident's care plan in the electronic medical record or hard copy. Staff #150 reported that the resident's decline may have been attributed to mood/behavior and the resident had a fall in March which required a CT scan of the head and cervical spine. However, there was no documentation of the interdisciplinary team's discussion of the decline and decision to revise the resident's care plan. Based on the reassessment of R#286's activities of daily living, the facility failed to revise the care plan to provide the necessary care or services that are consistent with the resident's abilities in activities of daily living.	4 175		
4 177	11-94.1-44(a) Specialized rehabiiltation services	4 177		

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(a) The facility shall provide for specialized and supportive rehabilitation services, including occupational therapy, physical therapy, and speech therapy, according to the needs of each resident, either directly by qualified staff or through arrangements with qualified outside resources. Services shall be programmed to:

(1) Preserve and improve the resident's maximal abilities for independent function;

(2) Prevent, insofar as possible, irreversible or progressive disabilities; and

(3) Provide for the procurement and maintenance of assistive devices as needed by the resident to adapt and function within the resident's environment.

This Statute is not met as evidenced by:
Based on record review and interview with staff members, the facility failed to ensure 1 of 3 residents (R#286) sampled for visual impairment received the proper treatment and assistive devices to maintain the resident's vision.

Findings include:

Cross Reference F278 and F279.

A record review done on the afternoon of 6/14/17 and morning of 6/15/17 found R#286 was admitted to the facility from an acute hospital on 2/8/17. The admission diagnoses include unspecified dementia with behavioral disturbance; unspecified psychosis not due to a substance or known physiological condition; other chronic pain; adjustment disorder with mixed anxiety and depressed mood; wandering in

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4 177	Continued From page 21 diseases classified elsewhere and anemia. A review of the resident's quarterly assessment found the resident is moderately impaired-limited vision, not able to see newspaper headlines but can identify objects with no corrective lenses (contacts, glasses, or magnifying glass). There is no documentation of the necessity of assistive devices to maintain her vision or whether the resident requires assistance to gain access to vision services by making appointments and arranging for transportation. An interview was done with the MDS Coordinators on 6/15/17 at 8:30 A.M. The coordinators confirmed on the initial assessment the visual impairment was missed; therefore, a care plan was not developed. Also, there is no documentation of the interdisciplinary team discussion of whether the resident would benefit from an appointment to assess the vision or acquisition of a visual device. The facility failed to ensure accurate assessment of R#286's vision; therefore, an assessment of the resident's need for an assistive device or appointment with an optometrist/ophthalmologist was not discussed.	4 177		
4 193	11-94.1-46(j) Pharmaceutical services (j) Medication errors and drug reactions shall be recorded in the resident's chart and reported immediately to the physician, physician assistant, or APRN who ordered the drug, and a medication error report shall be prepared and given to the administrator of the facility or director of nursing for review and appropriate action, according to facility policy.	4 193		

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This Statute is not met as evidenced by:
Based on observations and staff interviews the facility failed to ensure that administration of drugs and/or biologicals were in accordance with the physicians orders.

1) On 06/15/2017 at 9:29 AM observed Staff #241 administer medications to R#184. During the medication pull it was noted that Staff #241 pulled out "Artificial Tears Ung 1/2 inch intraocular Q HS (every bedtime) to both eyes". Queried Staff #241 if this is only applied at night and staff #241 stated "No the doctor said we could also do it in the morning also". Staff #241 gave morning medications to R#184 and applied eye ointment at that time. Review of R#184 medical record showed a doctor's order for "Artificial Tears Ung 1/2 inch intraocular Q HS to both eyes" with a diagnosis of "[redacted], as defined in USA". There was no doctor's order to apply Artificial Tears Ung in the AM as Staff #241 stated.

2) On 06/15/2017 at 10:12 AM observed Staff #241 pull medications for R #180. During this medication pull it was noted that Staff #241 pulled out two Acetaminophen 500 mg tablets which was to be given at 7 AM and 5 PM for pain. Staff #241 gave R #180 this prescribed 7 AM medication at 10:12 AM. Record review was done and order was written for "Tylenol Extra Strength 500 mg tablet po twice daily two tablets at 7 am and 5 pm for pain Generic: acetaminophen Other chronic pain".

On 06/15/2017 at 10:51 AM interviewed Staff #225 regarding medication times at the facility. Staff #225 stated "medication can be given up to

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4 193	Continued From page 23 one hour before and one hour after the ordered time." Staff #225 was shown that R #180 received a 7 AM medication after 10:12 AM. Reviewed the facilities' policy and procedure on "Administration of Medication" which stated under Standard "All medications are administered safely and appropriately to help residents overcome illness, relieve/prevent symptoms, and help in diagnosis." Also under Policy it states "A physician order that includes dosage, route, frequency, duration, and other required considerations including the purpose, diagnosis or indication for use is required for administration of medication." Under Procedure 6. it states "If there is any discrepancy between the MAR and the label, check physician orders before administering medication."	4 193		
4 218	11-94.1-55(e) Housekeeping (e) All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair. This Statute is not met as evidenced by: Based on observation and staff interview the facility failed to maintain resident care equipment and resident environment in sanitary condition and good repair. Findings include: 1) On 06/16/2017 at 8:02 AM while interviewing laundry staff #89 the two dryers were running. Staff #89 was asked if they could stop the dryers and check the lint traps. Staff #89 turned off the dryers and opened the lint traps. Lint traps for both dryers were filled with lint requiring Staff #89	4 218		

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4 218	Continued From page 24 to use a brush to sweep the lint out of the lint traps into the rubbish can. Queried when the dryer was turned on that day and staff stated "When we first start at 5 AM." Staff #89 was reminded that the laundry had to be washed first prior to going into the dryer at 5 AM and laundry staff #89 clarified that "the laundry was done last night and when we came in this morning we put it in the dryer". Staff #89 was asked to clarify this, did the laundry finish by midnight when the night shift staff are done with work and the laundry sits till 5 AM to be dried when the day shift staff start their shift? Laundry staff #89 confirmed this. Laundry staff #89 was asked when was the dryer lint trap cleaned last and they showed this surveyor the lint trap cleaning log and the last time the 2 dryer lint traps were cleaned was on 06/15/2017 at 11:15 PM by night shift staff. The next scheduled lint trap cleaning was for 9:30 AM that day. 2) On 06/16/2017 at 8:40 AM walked through the North Second unit's shower room with Staff #99 and observed darkened spots on the seat belt of the shower chair. Staff #99 was asked what the dark spots were but they were unable to determine what the darkened spots were. Staff #27 stated that the seat belt on the shower chair can be removed and washed. 3) On 06/16/2017 at 8:57 AM interviewed Staff #54 as we walked in the first floor shower room. It was noted that there were peeling non-skid adhesives on the floor that appeared to have been partially taken off of the floor. Staff #54 confirmed that these needed to be replaced. The South First shower room had a damaged baseboard that appeared to have some dark orange areas which Staff #54 confirmed that this needed to be fixed. When we went to the North	4 218		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HILO	944 WEST KAWAILANI STREET HILO, HI 96720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 218	Continued From page 25 Second shower room it was noted that the tile needed to be replaced as there were 4 tiles that were chipped, Staff #54 confirmed this. 4). On 06/16/2017 at 9:20 AM met with Staff #54 on South Second and asked him what they observed on the AC ducts, Staff #54 stated that it was "condensation and dust". Interview with Staff #54 found that housekeepers are responsible for cleaning the AC ducts. The facility failed to maintain clean dryer lint traps, sanitary shower chair, shower room tile and baseboard and AC ducts at the facility which may result in injury or spread of infection to the residents.	4 218		

This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.

RECEIVED
2011 AUG -3 P 12: 33
STATE OF HAWAII
DOH-OHCA MEDICARE

4 115 **07/31/2017**

Point 1 – Corrective Action for the Affected Residents

1. Staff were in-serviced on 7/25/2017 and 7/28/2017, on the necessity of assuring that care be provided in a manner that promotes, maintains and/or enhances a resident's quality of life, and recognizes each resident's individuality, with specific emphasis on dining and properly assisting residents during meals that included proper infection control measures and assuring resident dignity, respect, and individuality while assisting residents during meal times.

2. Staff were educated on 7/25/2017 and 7/28/2017 , on utilizing sinks at nurse's station and common areas when not in a resident room providing care and to focus on conversation that includes the resident when in a resident room.

3 Staff were educated on 7/25/2017 and 7/28/2017, on maintaining resident dignity and respect by referring to all residents by their preferred name, and on utilizing dignified language when referring to residents.

4 Staff were educated on 7/25/2017 and 7/28/2017, on maintaining resident dignity and respect when assisting resident with napkin placement during meals.

5 Staff were educated on 7/25/2017 and 7/28/2017, on the necessity of assuring resident privacy and confidentiality when providing care and on utilizing appropriate voice levels and assuring privacy when in resident areas.

Point 2 – Identification of Others Potentially Affected

On 7/31/2017, Department Heads and others as assigned, initiated discriminate monitoring of dining rooms and resident care areas to assure residents were treated with dignity and respect while being assisted with meals, napkins, personal care and that staff were addressing residents with appropriate language, including names and speaking to others in a dignified manner, and using proper voice tone when providing care. Any identified concerns were addressed at time of discovery.

Point 3 – Measures Put in Place; Systemic Changes

Department Heads, and others as assigned, will conduct weekly discriminate monitoring for 30 days to assure residents are treated with dignity and respect while being assisted with meals, napkins, personal care and that staff are addressing residents with appropriate language, including names and speaking to others in a dignified manner, and using proper voice tone when providing care. If concerns are noted, 1:1 in-service training will be conducted by the individual conducting the monitoring.

Point 4 – Monitoring

The Staff Development Coordinator/designee will provide the weekly discriminate monitoring audits to the Executive Director. Any trends or patterns noted related to staff not honoring resident privacy and confidentiality will be logged as a problem for the QAPI Committee and corrective action will be taken.

Point 5 – Date Corrective Action Will be Completed

July 31, 2017

RECEIVED
2017 AUG -3 P 12: 33
STATE OF HAWAII
DOH-OHCA MEDICARE

4 125 **07/31/2017**

Point 1 – Corrective Action for the Affected Residents
On 7/28/2017, staff were educated on the necessity of assuring resident privacy and confidentiality when providing care when roommate and/or visitors are present in resident rooms.

Point 2 – Identification of Others Potentially Affected
On 7/31/2017 department heads and others as assigned, completed discriminate monitoring on all units of staff actions when entering a resident room to be sure that measures are being taken by staff to assure resident privacy and confidentiality when providing care when roommate and or visitors are present in resident rooms. Any issues identified corrected at time of discovery.

Point 3 – Measures Put in Place; Systemic Changes
The Staff Development Coordinator, (SDC), or designee, will conduct weekly discriminate monitoring for 30 days of staff actions to be sure that staff are assuring resident privacy and confidentiality when providing care when roommate and/or visitors are present in resident rooms. If concerns are noted 1:1 in-service education will be provided by the individual conducting the discriminate monitoring.

Point 4 – Monitoring
The SDC/designee will provide the weekly discriminate monitoring audits to the Executive Director weekly. Any trends or patterns noted related to staff not honoring resident privacy and confidentiality will be logged as a problem for the Quality Assurance Performance Improvement (QAPI) Committee and corrective action will be taken.

Point 5 – Date Corrective Action Will be Completed
July 31, 2017

4 130 **07/31/2017**

Point 1 – Corrective Action for the Affected Residents
On 7/28/2017 resident #249 placed on a 1:1 to assure others are free from unwelcome touching and attention
On 7/28/2017, the facility sent referrals to other care providers seeking alternate placement for resident #249.

On 6/27/17, resident #249's behavior was reviewed by conducting staff interviews, the pharmacy consultant reviewed current medications with recommendations. PCP updated and agreeable.

Orders received, care plans, care directives, and medications updated, and interventions noted for resident #249.

Point 2 – Identification of Others Potentially Affected
On 6/19/17 through 7/2/2017, Social Services audited targeted behaviors on the behavior monitoring sheets for each resident by interviewing staff on all units regarding all the targeted behaviors for each resident on psychotropic medications. Any issues identified corrected at time of discovery.

Point 3 – Measures Put in Place; Systemic Changes
Social Services will review behaviors daily during grand rounds to verify that targeted behaviors, including inappropriate sexual touching, are being identified and appropriate interventions are implemented and reported per policy.

On 6/16/2017, 7/20/2017, 7/25/2017, and 7/28/2017 direct care staff were educated on interventions to redirect resident, safeguard others, and charting of behaviors for resident #249.

Social Services Director in-serviced Social Services staff on 6/19/17 regarding behavior monitoring.

On 7/20/17, 7/25/17, and 7/28/2017 the Director of Nursing educated staff on the importance of timely reporting of any inappropriate sexual behavior between residents, on the facilities behavior monitoring process, and on the importance of accurate documentation.

On 6/30/2017 and 7/28/2017, Staff Development Coordinator and Executive Director in-serviced all staff on the facilities abuse policy and procedures that included reporting and addressing inappropriate sexual behavior immediately.

Point 4 – Monitoring
Social Services will provide monitoring documentation to the Executive Director weekly for 30 days or until substantial compliance is maintained. Any identified concerns will be logged as a problem for the Quality Assurance Performance Improvement (QAPI) Committee and corrective action will be taken.

Point 5 – Date Corrective Action Will be Completed
July 31, 2017

4 149 **07/31/2017**

Point 1 – Corrective Action for the Affected Residents
On 6/15/2017, a hospice care plan was completed for resident #262.
On 6/24/2017, resident #313 was discharged from the facility.

Point 2 – Identification of Others Potentially Affected
On 6/21/2017, the Director of Nursing/designee completed 100% audit of residents receiving dialysis to assure appropriate documentation was included in the medical record form and to and from and to the dialysis center. Any identified concerns were addressed at the time of discovery.

On 7/25/2017, a 100% audit of hospice care plans was completed by MDS for accuracy. Any identified concerns were addressed at time of discovery.

Point 3 – Measures Put in Place; Systemic Changes
Nurse Managers will complete daily (dialysis day) audit of resident medical record to assure that documentation is completed appropriately by nursing home staff and dialysis center staff and that it is returned from the dialysis center when resident returns to the nursing home. This audit will include the completion of the pre/post dialysis communication tool by the dialysis facility, licensed nurses completion of their sections of the pre/post dialysis communication tool, entering dry weight in Softcare as well as assuring assessment of shunt site, thrill/bruit and bleeding documented in the MAR before and after dialysis, and obtaining labs/consults as ordered. Also, notify MD of any significant weight changes. This audit will continue for 30 days or until sustained compliance is achieved. The Director of Nursing/designee will complete weekly audit of dialysis communication documentation to assure thorough completion. This audit will continue for 30 days or until sustained compliance is achieved. If areas of concern are noted, the Director of Nursing/designee will complete one to one in-service education to licensed nurses and will contact the dialysis center management staff if necessary.

Director of Nursing, or designee, will randomly audit hospice care plans weekly for 30 days for accuracy and to verify that the care plan accurately reflects the MDS assessment. If concern noted, 1:1 in-service training will be provided by the Director of Nursing.

Point 4 – Monitoring
The Director of Nursing/designee will provide the hospice and dialysis audits to the Executive Director weekly. Any identified concerns will be addressed the QAPI Committee and corrective action will be taken.

Point 5 – Date Corrective Action Will be Completed
July 31, 2017

4 159 **07/31/2017**

Point 1 – Corrective Action for the Affected Residents
On 6/16/17, the items listed were discarded.

On 7/25/2017, and 7/28/2017, staff educated on proper hand hygiene after repositioning resident.

On 6/23/2017, The Food Service Director and Dietitian provided in-service training to dietary staff on the proper storage and labeling of food.

Point 2 – Identification of Others Potentially Affected
On 6/23/2017, the Dietary Manager and the Registered Dietitian audited every storage area on all units and kitchen. Any identified concerns were addressed at time of discovery.

On 7/31/2017, Department Heads/designees, initiated discriminate monitoring of dining rooms and resident care areas to assure staff is following proper hand hygiene techniques.

Point 3 – Measures Put in Place; Systemic Changes
The Food Service Director/designee will conduct a weekly audit for 30 days of all storage areas to ensure that all food items are properly stored and labeled.

Department Heads/designees, will conduct weekly discriminate monitoring of dining rooms for 30 days to assure staff is following proper hand hygiene while assisting residents. If concerns are noted, 1:1 in-service training will be conducted by the individual conducting the monitoring.

Point 4 – Monitoring
The Food Service Director/designee and SDC/designee will provide monitoring documentation to the Executive Director weekly for 30 days or until substantial compliance is maintained. Any identified concerns will be addressed by the PI Committee and corrective action will be taken.

Point 5 – Date Corrective Action Will be Completed
July 31, 2017

4 173 **07/31/2017**

Point 1 – Corrective Action for the Affected Residents
On 6/15/2017, a vision care plan was completed for resident #286.

On 6/15/2017, a hospice care plan was completed for resident #262.

On 6/24/2017, the behavior care plan was updated to more accurately reflect resident's behavior for resident #249.

Point 2 – Identification of Others Potentially Affected
A 100% audit of resident care plans was completed by MDS and Social Services to assure that vision (7/25/2017), hospice (7/25/2017), and behaviors (7/2/2017) are accurately documented. Any identified concerns were addressed at time of discovery.

Point 3 – Measures Put in Place; Systemic Changes
On 7/20/2017, the Director of Nursing provided education to nursing staff about updating care plans to accurately reflect vision needs, hospice care, and behaviors for each resident.

Director of Nursing, or designee, will randomly audit 3 to 5 vision, hospice, and behavior care plans weekly for 30 days for accuracy and to verify that the care plan accurately reflects the MDS assessment. If concern noted, 1:1 in-service training will be provided by the Director of Nursing.

Point 4 – Monitoring
The Director of Nursing/designee will provide monitoring documentation to the Executive Director weekly. Any identified concerns will be addressed the QAPI Committee and corrective action will be taken.

Point 5 – Date Corrective Action Will be Completed
July 31, 2017

4 175 **07/31/2017**

Point 1 – Corrective Action for the Affected Residents
7/27/2017 correction assessment was completed and the care plan for resident #286 updated to accurately reflect resident's condition.

Point 2 – Identification of Others Potentially Affected
On 7/25/2017, MDS completed a whole house audit comparing the most recent MDS assessment to the current MDS assessment for each resident looking for discrepancies and/or potential changes in condition. MDS's requiring correction were reviewed with the facilities Division Clinical Reimbursement Specialist who assisted with appropriate correction of each assessment identified at time of discovery.

Point 3 – Measures Put in Place; Systemic Changes
On 7/31/2017, MDS staff completed targeted in-service education in regards to appropriately identifying and completing significant change assessments.

Director of Nursing/designee, will randomly audit 3 to 5 MDS assessments weekly for 30 days to ensure accurate identification of assessments meeting significant change criteria or until sustained compliance achieved.

Point 4 – Monitoring
The Director of Nursing/designee will provide monitoring documentation to the Executive Director weekly. Any identified concerns will be addressed by the QAPI Committee and corrective action will be taken.

Point 5 – Date Corrective Action Will be Completed
July 31, 2017

4 177 **07/31/2017**

Point 1 – Corrective Action for the Affected Residents
On 6/15/2017, a vision care plan was completed for resident #286.

Point 2 – Identification of Others Potentially Affected
On 7/29/2017, the facility completed a 100% audit of residents vison care plans/care directives was completing by MDS to assure that all residents have appropriate care plans in place. Any identified concerns were addresses upon discovery.

Point 3 – Measures Put in Place; Systemic Changes
On 7/20/2017, the Director of Nursing provided education to nursing staff about updating care plans/care directives to assure that resident changes are accurately documented and assessed.

Director of Nursing, or designee, will randomly audit 3 to 5 MDS assessments weekly for 30 days to ensure accuracy of assessments or until sustained compliance achieved.

Point 4 – Monitoring
The Director of Nursing/designee will provide monitoring documentation to the Executive Director weekly. Any identified concerns will be addressed the QAPI Committee and corrective action will be taken.

Point 5 – Date Corrective Action Will be Completed
July 31, 2017

4 193 **07/31/2017**

Point 1 – Corrective Action for the Affected Residents
7/20/2017 the Director of Nursing/designee provided education to the identified licensed nurse about administering medication as ordered by the physician including the time of medication, assuring administration is within the acceptable standard of practice of 1 hour of physician ordered time frame and checking the physician order prior to administering any medication.

Point 2 – Identification of Others Potentially Affected
On 7/20/2017 the Director of Nursing/designee completed competency evaluation of medication administration for licensed nurses. This included education for any issues identified.

Point 3 – Measures Put in Place; Systemic Changes
Beginning 7/27/2017 the Director of Nursing/designee will complete discriminate monitoring of Medication Administration randomly and at least three times for each nurse within 60 days to assure that medications are administered per physician orders and acceptable standard of practice related to the 1 hour time frame and checking the physician order if there is a discrepancy between the MAR and the label. These observations will continue for 60 days or until substantial compliance is achieved.

Point 4 – Monitoring
The Director of Nursing will provide results of the weekly medication pass observations to the Executive Director weekly. Any trends or patterns noted will be logged as a problem by the QAPI committee and corrective action will be taken.

Point 5 – Date Corrective Action Will be Completed
July 31, 2017

Point 1 – Corrective Action for the Affected Residents
1. On 6/21/2017 and 7/1/2017, the Housekeeping/Laundry Supervisor conducted in-service training on maintaining proper cleaning of the dryer lint traps and on not leaving washed linen in the washing machine overnight.

2. On 6/16/17, the seat belt in question was removed and appropriately cleaned.
On 7/10/2017, the Director of Housekeeping/Laundry conducted in-service training on maintenance of shower chair belts.

On 7/6/2017, the Housekeeping/Laundry Supervisor ordered 10 new safety belts for PVC shower chairs and they were received on 7/14/2017.

3. On 7/26/2107, the shower room strips in the S1 shower were removed, floors cleaned, and base board repaired.

Non-skid product will be used on shower floors instead of non-skid strips.

On 7/27/2017, the damaged tiles on the N2 shower room were replaced.

4. On 6/16/17, the observed S2 AC duct was appropriately cleaned by housekeeping.

Point 2 – Identification of Others Potentially Affected
On 6/19/17, housekeeping staff cleaned all AC ducts in the facility.

On 6/19/2017, all shower chairs were inspected to ensure belts were clean and in good repair.

On 7/27/ 2017, the Housekeeping/Laundry Supervisor and the Maintenance Director checked all shower rooms. Any issues identified addressed at time of discovery.

Point 3 – Measures Put in Place; Systemic Changes
On 6/21/2017 and 7/1/2017, the Housekeeping/Laundry Supervisor in-serviced staff on the updated lint cleaning schedule and on not leaving wet laundry in the washer overnight.

AC Ducts will be cleaned weekly by housekeeping staff.

The Housekeeping/Laundry Supervisor and Maintenance Director will be educated on assuring that the lint cleaning schedule is verified and that wet laundry is not left in the washer overnight, maintaining shower belt chairs in clean and good repair, on cleaning AC ducts weekly, and on conducting bi-weekly inspection of shower room floor and base boards with the Maintenance Director.

The Housekeeping/Laundry Supervisor, or designee, will audit the lint cleaning schedule and verify that wet laundry is not being left over night in the washer, and will inspect shower chair seatbelts, and AC ducts weekly for 30 days to assure continued compliance and will check all shower room floors, and baseboards bi-weekly for 30 days with the Maintenance Director.

Shower chair seat belts will be changed and cleaned weekly, and PRN as needed. The Housekeeping/Laundry Supervisor will conduct a weekly review for 30 days to monitor for continued compliance.

The Housekeeping/Laundry Supervisor and the Maintenance Director will tour the facility and inspect all shower room floors and baseboards bi-weekly for 30 days to ensure that continued compliance is maintained.

Point 4 – Monitoring

The Housekeeping/Laundry and Maintenance Director will give the weekly audits to the Executive Director. Any identified concerns will be logged as a problem for the Quality Assurance Performance Improvement (QAPI) Committee and corrective action will be taken.

Point 5 – Date Corrective Action Will be Completed
July 31, 2017