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
	125033	A. BUILDING: _____ B. WING _____	07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CE	45-090 NAMOKU ST KANEOHE, HI 96744

(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 federal recertification and state licensure survey was conducted 7/11/2017-7/14/2017. The census on entrance to the facility was 42.	4 000	**4 000 11-94.1 Initial** This plan of correction is submitted to meet requirements established by state law. This plan of Correction constitutes the facility's demonstration of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency existed or that one was correctly cited.	
4 088	11-94.1-16(a) Governing body and management (a) Each facility shall have an organized governing body, or designated persons functioning as the governing body, that has overall responsibility for the conduct of all activities. The facility shall maintain methods of administrative management that assure that the requirements of this section are met. This Statute is not met as evidenced by: Based on observations, medication administration reports interviews and review of facility policies, the facility failed to maintain a quality assessment and assurance (QA&A) committee which included analyses of the identified performance improvement measures. This included specific standards for quality of care and outcomes related to the administration of medications at the correct time. In addition, nursing services was found to have no quality oversight as the nurses were not being monitored to identify care deficiencies for the resident population. Findings include: Observation of Staff #26 on 7/12/2017 observed 11 out of 25 medication administration opportunities were administered late. Medication administration reports were reviewed for the 7/1/2017, 7/8/2017 and 7/12/2017. The report for 7/1/2017 showed 51 medications were administered late for 18 residents. The report for 7/8/2017 showed 152 medications were administered late for 31 residents. The report for	4 088	**<u>4 088: 11-94.1-16(a) Governing body and management</u>** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 7/14/17, DON provided 1:1 training to staff #26 on proper medication administration focusing on the importance of prioritizing, organizing and properly administering medications. Staff #26 is no longer employed at facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents receiving medications from this nurse are potentially affected by the cited deficiency. **What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** (Continued...)	7/14/17

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: DON | (X6) DATE: 8/11/17

8/11/17: copy to EP; pr

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4 088	Continued From page 1 7/12/2017 showed that 95 medications were administered late for 22 residents. The medication administration reports showed that Staff #26 was the administrating nurse for the stated dates. An interview of the Director of Nursing, DON, on the afternoon of 7/12/17 revealed that staff were allowed to administer medications one hour before and one hour after the ordered medication times. The DON further noted that 16 of the 42 residents did not receive their medications on time on 7/12/17. A review of the facility's policy for Medication Administration with revision date of May 2016 revealed: "Administer medications within at least 60 minutes on each side of ordered time, except for 'Stat' medications which must be given immediately or other time-sensitive medications." An interview of Staff #26 on the morning of 7/14/17 at approximately 9:44 A.M. revealed she recently graduated from nursing school and reported this was her first job as a Registered Nurse. Staff #26 reported that she did not have a regular shift and usually filled in for nurses who were off. Staff #26 reported that she wasn't supposed to work on 7/12/17 but filled in for the nurse who was supposed to be there. Staff #26 reported that it's difficult for her to administer medications to the entire population of residents (current census: 42; certified for 44 beds). Staff #26 reported that she's unable to see the times of when all the medications are due (because of electronic records, she has to go into each resident's profile). She further noted that she starts her shift at 6:00 A.M. and takes report until approximately 6:30 to 6:45 A.M. Staff #26 then has to be in the dining room by 7:30 A.M. She is expected to take residents' blood pressures and sometimes the blood pressure machines don't work. When the machines don't work, she has to	4 088	(Continued...) On 8/8/17, DON provided in-service training to licensed nursing staff on Medication Administration including the importance of administering medications on time and avoiding common medication errors. **How the corrective action will be monitored to ensure the deficient practice will not recur:** DON or designee will audit the timeliness of Medication Administration by running a Medication Admin Audit Report. The audit report will be conducted, by DON or designee, weekly for 4 weeks, then monthly thereafter. DON or designee will conduct medication administration observations focusing on observing proper administration of medications. The medication observations will be conducted, weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. The observation audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	8/8/17 8/14/17 and ongoing 8/14/17 and ongoing 8/30/17

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4 088	Continued From page 2 manually check blood pressures. She stated, "It's challenging." In terms of prioritizing, Staff #26 reported, "everything is pretty much a priority. Every single person's medications are priorities. I'm not just cruising and ignoring the residents." She noted that she's very busy and tries really hard to keep up. Staff #26 further noted that she has to wait for the eMAR to load before she can begin her tasks. She admitted that ideally she would document and administer medications at the same time. Realistically, Staff #26 noted, she sometimes documented the administration of medications at a later time because she has so much to do. Staff #26 reported her understanding of the facility's policy was to administer medications one hour before and up to one hour after the medication order time. An interview of the Medical Director on the morning of 7/14/17 at approximately 10:50 A.M. revealed his understanding that the facility was experiencing staffing problems "this week". He further stated his desire to "eliminate the problem". Reference to Lipincott Safe Administration Practices states "To promote a culture of safety and to prevent medication errors, avoid distractions and interruptions when preparing and administering medications and adhere to the "five rights" of medication administration: identify the right patient by using at least two patient-specific identifiers, select the right medication, administer the right dose, administer the medication at the right time, and administer the medication by the right route." The facility failed to ensure that the QA&A committee had oversight of nursing staff were being monitored through quality and assessment to ensure that quality care deficiencies for the resident population were identified in the area of medication administration.	4 088		

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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 observations and staff interview, the facility failed to maintain respect and dignity for two residents, Resident #38 and Resident #57. Findings include: 1) During the lunch hour on 7/12/17, at approximately 12:40 P.M., an observation of Staff #26 found her passing medications to Resident #38. The staff member was reviewing Resident #38's electronic Medication Administration Record, eMAR, and made a grunting sound. The surveyor looked at the staff member and asked if she said something. Staff #26 replied, "[Resident #38] has medications ordered for 12:00 P.M. When [Resident #38] doesn't receive his medications at exactly 12:00, his wife gets mad." At that moment, an observation found Resident #38's wife seated next him at a table in the dining room looking over at Staff #26. Resident #38 and his wife were seated approximately 20 feet away	4 115	**4 115: 11-94.1-27(4) Resident rights and facility practices:** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 7/12/17, Residents #57, Resident #38 and Resident #38's wife had no concern or complaints On 7/19/17, staff #26 was in-serviced, by DON on dignity and respect. Staff #26 is no longer employed at this facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 7/14/17, DON conduct staff and resident interviews and observations, and no other residents were identified as being affected by this cited deficiency. **What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** On 8/8/17, the Administrator and DON provided in-service training to nursing staff on respect and dignity. The training emphasized the importance of providing care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	7/12/17 7/19/17 7/14/17 8/8/17

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4 115	Continued From page 4 from Staff #26. Resident #38's wife was not smiling and appeared upset. Resident #38 and his wife were within earshot of the nurse's statement. After Staff #26 made the comment about Resident #38's wife being mad, the wife turned to face Resident #38 and said something to him. When Staff #26 finally got to Resident #38's table, she apologized for being late. Resident #38's wife stated, "I would say this is really late." Staff #26 did not smile, did not interact with the resident and her facial expression appeared irritated and unfriendly. 2) Resident #57 was seated in the dining room at a table with 3 other residents during the lunch meal on 7/12/17 at approximately 12:50 P.M. Staff #26 brought Resident #57's medications to the table and announced that he was receiving a "laxative for your bowel movements" while his 3 table mates watched her giving Resident #57 his medications. 3) During the same medication pass for Resident #57 on 7/12/17 at approximately 12:50 P.M., Staff #26 administered an inhaler to him. After puffing the inhaler, Resident #57 rinsed his mouth and spit into an empty cup. Staff #26 placed the backwashed water on the table in front of Resident #57. She then gave him his pills, which he put in his mouth then picked up the backwashed water and drank that to wash down the pills. The nurse didn't notice Resident #57 drinking the backwash as she was distracted with uncoiling the blood pressure cuff. An interview of the Director of Nursing, DON, on the morning of 7/14/17 at approximately 11:15 A.M. revealed her displeasure in hearing of Staff #26's behavior. The DON further noted Staff #26 was a per diem nurse who was called in when	4 115	**How the corrective action will be monitored to ensure the deficient practice will not recur:** A focus audit was developed to address resident dignity during medication administration. The focus audit will be used as a structured format when medication administration observations are conducted. This focus audit will be conducted, by the DON or designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. The audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	8/11/17 8/14/17 and ongoing 8/30/17 and ongoing

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4 115	Continued From page 5 needed. The DON was unaware that Staff #26 was behaving in this manner and stated she would be working with her.	4 115		
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 observation, record review, and staff interview the facility failed to provide adequate supervision to prevent avoidable accidents for 1 of 2 residents. (Resident #53) Findings include: Resident #53, was admitted to the facility on 5/12/14 with generalized weakness related to cervical and lumbar/ sacral stenosis with myelopathy included in his diagnosis. He was admitted from home. On 7/12/17 at 1:00 PM Staff #50 was observed assisting Resident #53 transferring from the	4 136	**4 136 11-94.1-30 Resident Care:** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 7/31/17, DON in-serviced staff #50 on the proper practice for providing appropriate supervision while resident is in the bathroom. On 8/1/17, IDT reviewed and revised resident's plan of care to clarify instructions for supervision while resident is in the bathroom. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents who require visual supervision with toileting have the potential to be affected. On 8/7/17, these residents' care plans were reviewed and revised, by IDT, to ensure clarity of toileting intervention. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** (Continued...)	7/31/17 8/1/17 8/7/17

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4 136	Continued From page 6 wheelchair onto the toilet. Staff #50 closed the bathroom door which left Resident #53 unsupervised while using the toilet. Staff #50 waited outside of the bathroom until Resident #53 was finished. Staff #50 assisted Resident #53 to clean himself and assisted him back onto the wheelchair then to bed. When asked if Resident #53 has ever had a fall Staff #50 reported that Resident #53 had a fall during the evening shift in the past month and didn't know what the circumstances were or if Resident #53 was injured. Record review done on 7/13/17 found an annual Minimum Data Set (MDS) with assessment reference date (ARD) of 3/23/17 On the functional status, Section G., Resident #53 scored 3 in all categories of the activities of daily living (ADL) requiring extensive assistance while resident involved in activity, staff to provide weight bearing support. A review of the medical record revealed that Resident #53 had a fall documented on 6/29/17 that resulted in a skin tear to the right elbow. During a review of the care plan revision dated 07/11/2017 and "Kardex", it stated "Resident requires 1 person assist w/ cleaning self and transfers on/off toilet. Do NOT leave resident unattended during toileting". During an interview on 7/13/17 the Director of Nursing (DON) stated that resident #53 is being monitored for significant changes in his overall functional mobility for the past 2 weeks. When asked why the resident shouldn't be left unattended in the bathroom she reported that Resident #53 recently had a fall and is at risk for falls. If the main door to the room is closed, staff can leave the resident in the restroom allowing privacy while leaving the bathroom door partially open so visual observation is possible. The	4 136	(Continued...) All residents who require visual supervision with toileting have the potential to be affected. On 8/7/17, these residents' care plans were reviewed and revised, by IDT, to ensure clarity of toileting intervention. **What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** On 8/8/17, DON provided in-service training to the nursing staff on the proper practice for providing supervision when the resident is in the bathroom. **How the corrective action will be monitored to ensure the deficient practice will not recur.** A focus audit was developed to ensure residents receive adequate supervision when in the bathroom. The focus audit will be used as a structured format when conducting observations during resident care. This focus audit will be conducted, by DON or designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. The audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	8/7/17 8/8/17 8/11/17 8/18/17 and ongoing 8/30/17 and ongoing

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4 136	Continued From page 7 Kardex is a CNA's reference for treatment. The DON also stated that in order to do a root cause analysis when a resident has a fall the team will meet to review the details of the fall, assess for injuries, and ask the resident what was needed at the time the fall occurred. When Resident #53 fell he may have had to go to the bathroom and forgot to use the call light. During the interview with Staff #11, the staff concurred with the DON that the resident should not be left unattended while in the bathroom. The staff member recalled Resident #53 forgot to use the call light and was trying to reach over to put his shoes on, lost his balance and fell. The facility failed to provide adequate supervision of Resident #53 by not following the resident care instructions noted on the Kardex the resident was left unattended while using the toilet.	4 136	**4 148: 11-94.1-39(a) Nursing Services:** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** 1. On 7/14/17, DON provided 1:1 training to staff #26 on proper medication administration focusing on the importance of prioritizing, organizing and properly administering medications. Staff #26 is no longer employed at facility. 2. On 7/31/17, DON met with staff on the importance of timely response to resident call lights and residents' requests for assistance. 3. On 7/31/17, DON met with staff #50 and nursing staff on the length of wait time for Resident #22 to determine a system to promote timely attention to resident's needs. 4. On 7/14/17, DON reviewed with staff #52 the process for tray delivery including the importance of ensuring diet textures are accurate and that residents receive the necessary level of assistance. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this cited deficiency.	7/14/17 7/31/17 7/31/17 7/14/17
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on interviews, medication administration reports and observation the facility failed to ensure that sufficient qualified nursing staff were available on a daily basis to meet residents' needs for nursing care in a manner and in an environment which promotes each resident's	4 148		

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4 148	Continued From page 8 physical, mental and psychosocial well-being to enhance their quality of life. Findings include: Observation of Staff #26 on 7/12/2017 observed 11 out of 25 medication administration opportunities were administered late. Medication administration reports were reviewed for the 7/1/2017, 7/8/2017 and 7/12/2017. The report for 7/1/2017 showed 51 medications were administered late for 18 residents. The report for 7/8/2017 showed 152 medications were administered late for 31 residents. The report for 7/12/2017 showed that 95 medications were administered late for 22 residents. The medication administration reports showed that Staff #26 was the administrating nurse for the stated dates. An interview of the Director of Nursing, DON, on the afternoon of 7/12/17 revealed that staff were allowed to administer medications one hour before and one hour after the ordered medication times. The DON further noted that 16 of the 42 residents did not receive their medications on time on 7/12/17. A review of the facility's policy for Medication Administration with revision date of May 2016 revealed: "Administer medications within at least 60 minutes on each side of ordered time, except for 'Stat' medications which must be given immediately or other time-sensitive medications." An interview of Staff #26 on the morning of 7/14/17 at approximately 9:44 A.M. revealed she recently graduated from nursing school and reported this was her first job as a Registered Nurse. Staff #26 reported that she did not have a regular shift and usually filled in for nurses who were off. Staff #26 reported that she wasn't supposed to work on 7/12/17 but filled in for the	4 148	**What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** 1. On 8/6/17 a review of medication administration times was completed. Based on resident preferences and medication administration guidelines, medication administration times were adjusted to promote timely administration of medications. On 8/8/17, DON provided in-service training to licensed nursing staff regarding Medication Administration including the importance of administering medications on time and ways to avoid common errors. 2. On 8/8/17, DON and Administrator in-serviced nursing staff on the importance of timely response to resident call lights and residents' requests for assistance. 3. By 8/30/17, CNA assignments will be restructured to 2 teams to promote communication and timely attention to resident's needs through teamwork. 4. On 8/8/17, DON and Administrator in-serviced nursing staff on the process for tray delivery including the importance of ensuring that the diet texture is accurate and the resident receives the necessary level of assistance.	8/6/17 8/8/17 8/8/17 8/30/17 8/8/17

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4 148	Continued From page 9 nurse who was supposed to be there. Staff #26 reported that it's difficult for her to administer medications to the entire population of residents (current census: 42; certified for 44 beds). Staff #26 reported that she's unable to see the times of when all the medications are due (because of electronic records, she has to go into each resident's profile). She further noted that she starts her shift at 6:00 A.M. and takes report until approximately 6:30 to 6:45 A.M. Staff #26 then has to be in the dining room by 7:30 A.M. She is expected to take residents' blood pressures and sometimes the blood pressure machines don't work. When the machines don't work, she has to manually check blood pressures. She stated, "It's challenging." In terms of prioritizing, Staff #26 reported, "everything is pretty much a priority. Every single person's medications are priorities. I'm not just cruising and ignoring the residents." She noted that she's very busy and tries really hard to keep up. Staff #26 further noted that she has to wait for the eMAR to load before she can begin her tasks. She admitted that ideally she would document and administer medications at the same time. Realistically, Staff #26 noted, she sometimes documented the administration of medications at a later time because she has so much to do. Staff #26 reported her understanding of the facility's policy was to administer medications one hour before and up to one hour after the medication order time. An interview of the Medical Director on the morning of 7/14/17 at approximately 10:50 A.M. revealed his understanding that the facility was experiencing staffing problems "this week". He further stated his desire to "eliminate the problem". The facility failed to ensure there were sufficient licensed nursing staff to administer residents their medications on time.	4 148	**How the corrective action will be monitored to ensure the deficient practice will not recur:** 1. DON or designee will audit the timeliness of Medication Administration by running a Medication Admin Audit Report weekly for 4 weeks, then monthly thereafter. 2. A focus audit (including resident interviews) was developed as a structured format to audit timely response to resident call lights and to residents request for assistance. This focus audit will be conducted by the Administrator or designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. 3. A focus audit was developed as a structured format to monitor tray delivery for accuracy of diet texture and ensuring the resident receives the necessary level of assistance required. This focus audit will be conducted by the Food Service Director or designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters The audits (1-3) will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	8/14/17 and ongoing 8/11/17 8/18/17 and ongoing 8/18/17 and ongoing 8/11/17 8/30/17 and ongoing

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4 148	Continued From page 10 2) During an interview with Resident #59 on the 7/11/2017 at 10:40 AM, she responded to the question "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" with "Depends on length of time, sometimes waits 10-40 minutes." She did go onto say she had never soiled herself waiting for assistance but often waits 40 minutes which she stated "is too long". The facility failed to ensure there is sufficient nursing staff to meet the resident's daily basic needs. 3) On 7/11/17 at 10:51 AM, during an interview of Res #2, she had the following response to whether there was sufficient staff available to make sure she received the care and assistance without having to wait a long time: "No, no period! That's because of the rules of what we're allowed to have, which is only so many people. That's one of my things I keep trying to tell them they don't have enough staff. I've had to wait a long, long time for a lot of times. I know it's not because they don't want to help me, it's because they don't have enough people to do it. I think it's important for them to have more people. And they can't do anything about it. The morning shift, definitely, it always takes a long time for anyone to help you. And when you think you have to go to the bathroom and you feel like you're going to explode, it's very uncomfortable. It's when you're awake, waking up in the morning." 4) On 7/13/17, surveyor observed the night to early morning shift transition at 5:37 AM in the facility. It was revealed there were two certified nurse aides (CNAs) and one licensed nurse for	4 148		

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4 148	Continued From page 11 the night shift. Also, a restorative nurse aide (RNA) (Staff #50) and another CNA "floater" arrived at 5:30 AM. During the observation of care for Res #22 at 5:42 AM, Res #22 was sitting in his wheelchair in his bedroom. He was placed in front of his wash basin and was staring in the mirror. There was a small dixie cup with water placed on the top of the basin. At 6:00 AM, Res #22 was still sitting in the same spot. He also had a small white wash cloth on his lap and a blue towel, but no oral care or other personal care/grooming items were seen. The resident stated he was "okay" and said he was waiting for the staff "to pick me up." There was no call light within reach for the resident to use. Although the CNA floater who came in at 5:30 AM was in the hallway starting showers for other residents, she did not realize this resident was waiting to be "picked up." At 6:12 AM, the resident was still in the same spot sitting in his wheelchair in front of his wash basin. At 6:19 AM, surveyor asked Res #22 if he brushed his teeth. He replied he did and opened the mounted cabinet door to show where his oral care items were. Res #22 then said, "they're supposed to come and get me." He acknowledged the staff was to come and get him. On the same morning, 7/13/17 at 6:22 AM, Staff #45 stated with just the two night shift CNAs, "sometimes it's very hard because only the two of us, and doing our very best to answer our lights." Staff #45 said the charge nurse also helped out, but "we are running, yes" and said even though at 5:30 AM, an additional RNA and CNA came in to help them, Staff #45 said it really was not a relief for them. Staff #45 said this was because during the last morning rounds, the residents start awakening at 5:00 to 5:30 AM; that "they start using the bathroom, you know getting up. Expectation is 2-3 minutes to answer (call lights)	4 148		

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4 148	Continued From page 12 most of time, but we are brisk walking." Staff #45 said some of the residents ask them, "How come so long? So I have to tell them, and I have to prioritize." Staff #45 was then asked about Res #22. Staff #45 said she thought the CNA "floater" was taking care of him and said, "I have to set him up to brush his teeth, comb his hair and if I have enough time, to pick up him, but I expect the floater to pick him up or the RNA because he supposed to be outside. I don't know who is the RNA." Staff #45 then said, "(Staff #50) is to pick him up because he's been set up. I think he's (Staff #50) busy." At 6:31 AM, Staff #45 then went to check on Res #22 and saw him still sitting in front of his wash basin. Staff #45 apologized to the resident and said the RNA was supposed to have come to get him. Staff #45 then stated she would take the resident "to the love of your life" and wheeled him into the activity/TV room to sit beside his spouse, who had been sitting in the activity/TV room upon surveyor's arrival at 5:37 AM. Once Res #22 was positioned next to his spouse, they held hands and watched TV. He had been waiting for close to an hour in his room, and had it not been brought to Staff #45's attention, none of the staff would have attended to him sooner. The resident had no call light available for him to use as well and stated twice that he was waiting for the staff to come and get him. On 7/13/17 at 6:33 AM, Staff #50 said, "Yes, I was supposed to get him but I was busy answering the lights." The early morning observations found this staff answering the residents' call lights along with the other two night shift CNAs and that it was a very busy time for	4 148		

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4 148	Continued From page 13 them. Amongst Staff #50, Staff #45 and Staff #33, Staff #33's face was full of perspiration as she was running in and out of the residents' rooms to get water, to get them up and to answer the next resident's call light, etc., during the morning rounds. Staff #45 said she wore a knit cap to absorb the perspiration around her forehead, but her face was also glistening with beads of perspiration. Staff #50 was also busy bringing residents out of the room in addition to constantly going into different residents' rooms to answer the morning call lights. 5) Res #29 was observed with her breakfast tray on 7/13/17 at 7:54 AM. The resident's dietary order was for a Level 3 bite size consistency. However, her plate consisted of one french toast, no crust, but cut into three long strips (not bite sized), and a whole, unpeeled banana. At 7:56 AM, licensed staff #11 acknowledged that Res #29's food was not of the bite sized consistency. Staff #11 also stated at 8:09 AM that her expectation was that at all levels of care, i.e., the kitchen, licensed staff, the CNAs, they were responsible to ensure the menu and diet consistency was correctly served to the resident. Staff #11 stated, "And also looking at her tray, we should be doing a check--a process that should be from the start of the tray (service) to the finish line when it meets the resident." On 7/13/17 at 8:14 AM, Staff #52 said, "It's my mistake, I know it's not chopped, I normally don't chop it because she always say she can do. I supposed to have chopped it up for her." 6) On 7/11/17 during stage 1 resident interview when asked "if you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time"? Resident #31 stated "It takes a while to get	4 148		

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4 148	Continued From page 14 help when you call, if calling during meal times it takes longer". It's worse for him (she pointed to Resident #53 in the bed next to hers) because he just can't wait and will have an accident". Resident #53 he replied " Sometimes I have to wait a long time and I have to let it go". 7) On 7/14/17 during Resident Council Interview with Resident #2 when asked if appropriate facility staff respond to the resident's /group's concerns? Resident #2 stated " If they can, the problem is theres not enough people working here, the residents can't wait for 20 minutes when they call for help".	4 148	**4 149: 11-94.1-39(b) Nursing Services** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 7/17/17, MDS Coordinator and Social Services Director developed a comprehensive care plan addressing resident #61's antidepressant drug use. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 8/1/17, Social Services Director, DON and Activity Director reviewed care plans for all residents receiving an antidepressant medication to ensure that each resident had a comprehensive care plan addressing antidepressant drug use. **What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** On 8/8/17, the DON provided in-service training to licensed nursing staff on the importance of care planning antidepressant use. On admission, quarterly with the MDS schedule, and with any significant change in condition, the use of antidepressant medication will be reviewed and care plans revised accordingly by the MDS Coordinator and Social Services Director.	7/17/17 8/1/17 8/8/17 8/1/17 and ongoing
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of	4 149		

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4 149	Continued From page 15 direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on record review and interview with facility staff, the facility failed to develop a comprehensive care plan with measurable objectives and timeframe for 1 of 24 residents reviewed for care plans in Stage 2 (Resident #61). Findings include: Resident #61, was admitted to the facility on 6/14/17 with diagnosis which included an adjustment disorder with depressed mood. The resident was admitted from home. Record review done on 7/14/17 of the admission Minimum Data Set (MDS)with an assessment reference date (ARD)of 6/20/17, Resident #61 scored a "1" for mood and behavior which indicates infrequent episodes of sadness. The care area assessment summary noted Psychotropic drug use was triggered and the decision to develop a care Plan. Review of the care plan found there were no goals or objectives documented to monitor for anti-depressant drug use or mood. A review of the progress notes in the skilled nursing section of the electronic medical record (EMR)did not contain documentation about the resident's mood. During an interview, Staff #11 stated that Resident #61 was admitted as a short stay with weight loss, back pain and generalized weakness, and came into the facility on Mirtazapine 7.5 mg that was being taken at home. Staff #11 stated the Mirtazapine is often	4 149	**How the corrective action will be monitored to ensure the deficient practice will not recur:** A focus audit was developed to address appropriate care planning of antidepressant medications use. This focus audit will be conducted by Social Services Director, MDS Coordinator or designee, weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. The audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	8/11/17 8/18/17 and ongoing 8/30/17 and ongoing

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4 149	Continued From page 16 prescribed to residents to increase appetite. Resident #61 had a loss of appetite and lack of interest in activities. There is no care plan for use of an anti-depressant, appetite stimulant and / or sad mood. The facility did not develop a comprehensive care plan for anti-depressant use for Resident #61.	4 149		
4 152	11-94.1-39(e) Nursing services (e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures. The policies and procedures shall include but not be limited to: (1) Written procedures for personnel to follow in an emergency including: (A) Care of the resident; (B) Notification of the attending physician and other persons responsible for the resident; and (C) Arrangements for transportation, hospitalization, or other appropriate services; (2) All treatment and care provided relative to the resident's needs and requirements for documentation; and (3) Medication or drug administration procedures that clearly define drug administration process,	4 152	**4 152: 11-94.1-39(e) Nursing Services** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 7/14/17, DON provided 1:1 training to staff #26 on proper medication administration focusing on the importance of prioritizing, organizing and properly administering medications. Staff #26 is no longer employed at facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents were potentially affected by the cited deficiency	7/14/17

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4 152	Continued From page 17 documentation, and authorized This Statute is not met as evidenced by: Based on observation, medication administration report reviews and interviews, the facility failed to ensure administration of medications were being provided by nursing staff to meet professional stands of quality and care. Findings include: Observation of Staff #26 on 7/12/2017 observed 11 out of 25 medication administration opportunities were administered late. Medication administration reports were reviewed for the 7/1/2017, 7/8/2017 and 7/12/2017. The report for 7/1/2017 showed 51 medications were administered late for 18 residents. The report for 7/8/2017 showed 152 medications were administered late for 31 residents. The report for 7/12/2017 showed that 95 medications were administered late for 22 residents. The medication administration reports showed that Staff #26 was the administrating nurse for the stated dates. An interview of the Director of Nursing, DON, on the afternoon of 7/12/17 revealed that staff were allowed to administer medications one hour before and one hour after the ordered medication times. The DON further noted that 16 of the 42 residents did not receive their medications on time on 7/12/17. A review of the facility's policy for Medication Administration with revision date of May 2016 revealed: "Administer medications within at least 60 minutes on each side of ordered time, except for 'Stat' medications which must be given immediately or other time-sensitive medications." An interview of Staff #26 on the morning of	4 152	**What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** On 8/8/17, DON provided in-service training to licensed nursing staff on nursing professional standards of administering medications including the importance of administering medications at the right time. **How the corrective action will be monitored to ensure the deficient practice will not recur:** A focus audit was developed to ensure that all residents' medications are being administered at the right time. The focus audit will be used as a structured format when medication administration observations are conducted. This focus audit will be conducted, by the DON or designee, weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. The audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	8/8/17 8/11/17 8/14/17 and ongoing 8/30/17 and ongoing

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4 152	Continued From page 18 7/14/17 at approximately 9:44 A.M. revealed she recently graduated from nursing school and reported this was her first job as a Registered Nurse. Staff #26 reported that she did not have a regular shift and usually filled in for nurses who were off. Staff #26 reported that she wasn't supposed to work on 7/12/17 but filled in for the nurse who was supposed to be there. Staff #26 reported that it's difficult for her to administer medications to the entire population of residents (current census: 42; certified for 44 beds). Staff #26 reported that she's unable to see the times of when all the medications are due (because of electronic records, she has to go into each resident's profile). She further noted that she starts her shift at 6:00 A.M. and takes report until approximately 6:30 to 6:45 A.M. Staff #26 then has to be in the dining room by 7:30 A.M. She is expected to take residents' blood pressures and sometimes the blood pressure machines don't work. When the machines don't work, she has to manually check blood pressures. She stated, "It's challenging." In terms of prioritizing, Staff #26 reported, "everything is pretty much a priority. Every single person's medications are priorities. I'm not just cruising and ignoring the residents." She noted that she's very busy and tries really hard to keep up. Staff #26 further noted that she has to wait for the eMAR to load before she can begin her tasks. She admitted that ideally she would document and administer medications at the same time. Realistically, Staff #26 noted, she sometimes documented the administration of medications at a later time because she has so much to do. Staff #26 reported her understanding of the facility's policy was to administer medications one hour before and up to one hour after the medication order time. An interview of the Medical Director on the morning of 7/14/17 at approximately 10:50 A.M.	4 152		

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4 152	Continued From page 19 revealed his understanding that the facility was experiencing staffing problems "this week". He further stated his desire to "eliminate the problem". Reference to Lipincott Safe Administration Practices states "To promote a culture of safety and to prevent medication errors, avoid distractions and interruptions when preparing and administering medications and adhere to the "five rights" of medication administration: identify the right patient by using at least two patient-specific identifiers, select the right medication, administer the right dose, administer the medication at the right time, and administer the medication by the right route." The facility failed to ensure that the nursing professional standard of administrating medication at the right time occurred.	4 152		
4 185	11-94.1-46(b) Pharmaceutical services (b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and director of nursing that: (1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs; (2) Is reviewed at least every two years and	4 185	**4 185: 11-94.1-46(b) Pharmaceutical Services** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 7/19/17, DON in-serviced Staff #26 on the proper handling and storage of medications. Staff #26 is no longer employed at facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** (Continued...)	7/19/17

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4 185	Continued From page 20 revised as necessary to keep abreast of current developments in overall drug usage; and (3) Has a drug recall procedure that can be readily implemented. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to properly store medications. Findings include: Observations of Staff #26 on the afternoon of 7/12/17 revealed her failure to properly store medications. An observation of medication administration on the afternoon of 7/12/17 at approximately 12:40 P.M. found Staff #26 passing medications to Resident #38 in the dining room. Staff #26 left the following blister packs of medications out, on top of her medication cart: Carbidopa-Levodopa 25-100 tablets; Carbidopa-Levo ER 25-100 tablets; and Entacaprone 200 mg tablets. Staff #26 did not lock her medication cart when she went to Resident #38's table to give him his medications. Resident #38's wife informed Staff #26 that the resident disliked chocolate pudding and would prefer vanilla pudding. Since she didn't give Resident #38 his medications, Staff #26 needed to place the medications somewhere. She decided to place Resident #38's medications into a small plastic bag and placed the bag into her shirt pocket and took it with her to get the vanilla pudding. Upon return, Staff #26 removed the plastic bag from her pocket and poured the medications into a medication cup then gave Resident #38 his medications. These observations occurred during the lunch hour on 7/12/17 when there were several visitors and at	4 185	(Continued...) According to Staff #26 this was the only time that she had handled a resident's medications in such a manner. This appears to have been an isolated event and no other residents were identified to have been affected by the cited deficiency. **What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** On 8/8/17, DON provided in-service training to licensed nursing staff regarding the proper handling and storage of medications. **How the corrective action will be monitored to ensure the deficient practice will not recur:** A focus audit was developed to address proper medication handling and storage. The focus audit will be used as a structured format when medication administration observations are conducted. This focus audit will be conducted, by DON or designee weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. The audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	7/19/17 8/8/17 8/11/17 8/14/17 and ongoing 8/30/17 and ongoing

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4 185	Continued From page 21 least 15 residents in the dining room. An interview of the DON on the morning of 7/14/17 revealed that Staff #26 should have labeled Resident #38's medications and placed them in a drawer of the medication cart, locked it, then moved on to the next task. The DON further noted that Staff #26 should have placed Resident #38's medication blister packs back into the medication cart then locked it. The DON further clarified that nurses were expected to lock their medication carts anytime it would be unattended. The facility failed to properly store/secure medications, leaving residents and visitors at risk for injury.	4 185		
4 192	11-94.1-46(i) Pharmaceutical services (i) Appropriately licensed and trained staff shall be responsible for the entire act of medication administration, which entails removing an individual dose from a container properly labeled by a pharmacist or manufacturer (unit dose included), verifying the dosage with the physician's orders, giving the specified dose to the proper resident, and promptly recording the time, route, and dose given to the resident, and signing the record. Only a licensed nurse, physician, or other individual to whom the licensed professional has delegated the responsibility pursuant to chapter 16-89, subchapter 15, may administer medications. This Statute is not met as evidenced by: Based on observations, staff interviews, review of the electronic Medication Administration Record	4 192	**4 192: 11-94.1-46(i) Pharmaceutical Services** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 7/12/17, DON notified the physician for Resident #38 and Resident #57 of the delay in medication administration. On 7/14/17, DON provided 1:1 training to staff #26 on proper medication administration focusing on the importance of prioritizing, organizing and properly administering medications. Staff #26 is no longer employed at facility.	7/12/17 7/14/17

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4 192	Continued From page 22 (eMar) and facility policy review, the facility failed to administer medications in a timely manner resulting in a medication error rate which was greater than 5 percent. Findings include: An observation of Staff #26 on the afternoon of 7/12/17 found that 11 out of 25 medication opportunities were administered late resulting in an error rate of 42.3%. An interview of Staff #26 revealed that she failed to administer the morning medications for Residents #38 and #57 because she was "giving medications to other residents". Staff #26 stated the facility's policy indicated an acceptable time frame for medication administration was one hour before and one hour after the ordered medication times. An interview of the Director of Nursing, DON, on the afternoon of 7/12/17 revealed that staff were allowed to administer medications one hour before and one hour after the ordered medication times. The DON further noted that 16 of the 42 residents did not receive their medications on time on 7/12/17. A review of the facility's policy for Medication Administration with revision date of May 2016 revealed: "Administer medications within at least 60 minutes on each side of ordered time, except for 'Stat' medications which must be given immediately or other time-sensitive medications." The facility had a medication error rate of 42.3% based on the delay of morning medications on the day of 7/12/17.	4 192	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 7/12/17, a review of the eMAR was performed by the DON to identify other residents who experienced a delay in the administration of their morning medications. The physicians for these residents were informed of the delay in medication administration. **What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** On 8/8/17, DON provided in-service training to licensed nursing staff regarding Medication Administration including the importance of administering medications on time and ways to avoid delays. **How the corrective action will be monitored to ensure the deficient practice will not recur:** DON will audit the timeliness of Medication Administration by running a Medication Admin Audit Report. The audit report will be conducted, by DON or designee, weekly for 4 weeks, then monthly thereafter. The audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	7/12/17 8/8/17 8/14/17 and ongoing 8/30/17 and ongoing

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4 193	Continued From page 23	4 193		
4 193	11-94.1-46(j) Pharmaceutical services (j) Medication errors and drug reactions shall be recorded in the resident's chart and reported immediately to the physician, physician assistant, or APRN who ordered the drug, and a medication error report shall be prepared and given to the administrator of the facility or director of nursing for review and appropriate action, according to facility policy. This Statute is not met as evidenced by: Based on observations, medical record review, staff interviews and facility policy review, the facility experienced significant medication errors for 2 of 42 residents, Resident #116 and Resident #118. Findings include: Observation of Staff #26 performing medication administration on the afternoon of 7/12/17 revealed she failed to provide 16 of 42 residents with their morning medications. Of the 16 affected residents, two residents (Residents #116 and #118) experienced negative outcomes which may have been related to the delay in receiving their morning doses. 1) A medical record review for Resident #118 found she was admitted to the facility on 7/6/17 with diagnoses which included a fracture of her left elbow. An interview of Staff #11 on the morning of 7/11/17 found Resident #118 was experiencing poor oral intake and had received 1 liter of intravenous (IV) fluids on the night of 7/10/17 to maintain her hydration status. According to Staff #11 she completed the IV fluids and would be reassessed on the morning of	4 193	**4 193: 11-94.1-46(j) Pharmaceutical Services:** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 7/12/17, the physician for Resident #116 and Resident #118 were informed of Staff #26's delay in receiving their morning dose of medication and the possibility that the delay may have a caused the resident to experience outcomes. On 7/14/17, DON provided 1:1 training to staff #26 on proper medication administration focusing on the importance of prioritizing, organizing and properly administering medications in a timely manner. Staff #26 is no longer employed at facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this practice. DON performed a review of the residents who had experienced a delay in receiving their morning medications; no other residents were identified.	7/12/17 7/14/17 7/12/17

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4 193	Continued From page 24 7/11/17. Resident #118's physician's orders included: 1) MS Contin extended release tablet 15 mg (narcotic for pain); Give one tablet orally two times a day for pain; Hold medication if resident is lethargic; 2) Lidocaine Patch 5%, Apply 2 patch transdermally one time a day for chronic back pain, Apply 1 patch to back of right arm and shoulder and another patch to lower back, Do not leave on for more than 12 hours and remove per schedule; 3) Morphine Sulfate Solution 10 mg/5 ml, Give 1.25 ml orally every 2 hours as needed for mild pain/discomfort, Give 1.25 ml to equal 2.5 mg dose po/sl PRN; 4) Morphine Sulfate 10 mg/5 ml, Give 2.5 ml orally every 2 hours as needed for moderate pain/discomfort, Give 2.5 ml to equal 5 mg dose po/sl PRN. A review of the nurses notes found an entry dated 7/12/17: "...Denies pain or shortness of breath at rest but with any turning her pain goes up to 8-10 (10=highest amount of pain) to the left arm and lower back/pelvis. The resident received her routine MS Contin. Lidoderm patch applied to her lower back and her left arm. Left arm continues in ace wrap with soft cast intact..." A review of the eMAR for 7/12/17 revealed Resident #118 did not receive her routine pain medication, MS Contin extended release 15 mg tablet oral twice daily, per the physician's order at 9:00 A.M. Instead the MS Contin was given at 12:33 P.M. Resident #118 had physician's orders for routine narcotics for pain management, indicating the necessity for around the clock routine dosing to minimize the level of pain she was experiencing. The delayed administration of 3 hours and 33 minutes on 7/12/17 may have contributed to increased pain for Resident #118.	4 193	**What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** On 8/8/17, DON provided in-service training to licensed nursing staff regarding Medication Administration including the importance of administering medications on time and ways to avoid delays. **How the corrective action will be monitored to ensure the deficient practice will not recur:** DON will audit the timeliness of Medication Administration by running a Medication Admin Audit Report. The audit report will be conducted, by DON or designee, weekly for 4 weeks, then monthly thereafter. The audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	8/8/17 8/14/17 and ongoing 8/30/17 and ongoing

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4 203	Continued From page 25	4 203	**4 203 11-94.1-53(a) Infection Control**	
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain a safe and sanitary environment. Findings include: An observation of Staff #26 on the afternoon of 7/12/17 at approximately 12:45 P.M. found a break in infection control. During medication administration to Resident #57, Staff #26 dropped his inhaler on the floor, picked it up, wiped it down with a PDI wipe, opened the inhaler, placed it on Resident #57's mouth and administered the puffs. Staff #26 did not allow the PDI solution to dry and did not sanitize her hands prior to administering the medication. An interview of the DON on the morning of 7/14/17 at approximately 10:43 A.M. found that she expected Staff #26 to allow the PDI solution to dry and to wash/sanitize her hands before going forward with administering the medication to Resident #57. The facility failed to maintain a safe and sanitary environment for Resident #57 during medication administration on the afternoon of 7/12/17.	4 203	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On 7/19/17, DON in-serviced Staff #26 on proper hand hygiene and how to properly disinfect an inhaler. Staff #26 is no longer employed at facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents receiving medications from this nurse were reviewed and no other residents were identified as being affected by the cited deficiency. **What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:** On 8/8/17, DON provided in-service training to licensed nursing staff regarding proper hand hygiene during medications administration and proper cleaning and disinfecting procedure of inhalers. **How the corrective action will be monitored to ensure the deficient practice will not recur:** (Continued...)	7/19/17 7/19/17 8/8/17

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			(Continued...) A focus audit was developed to address proper hand hygiene, proper cleaning and disinfecting of inhaler during medication administration. The focus audit will be used as a structured format when medication administration observations are conducted. This focus audit will be conducted, by DON, weekly for 4 weeks, monthly for 2 months, and quarterly for 3 quarters. The audits will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	8/11/17 8/14/17 and ongoing 8/30/17 and ongoing