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
	125010	A. BUILDING: _____ B. WING _____	08/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

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4 000	11-94.1 Initial Comments A relicencing survey was conducted from 08/14/17 to 8/17/17 and was completed on 8/21/17. The facility census included 112 residents upon entrance.	4 000		
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 observation and staff interviews, the facility failed to provide visual privacy of a resident's body during the provision of care for 1 of 32 residents (Resident #118). Finding includes: On 08/14/2017 at 9:43 AM, surveyor observed Resident #118 (Res #118) turned to her left side through the open door of her room and through both the anteroom's window and her bedroom window. The resident was totally naked while personal care was being done for her by two certified nurse's aides (CNAs) at her bedside. Staff #39 came to observe and said, "Oh, privacy." Staff #39 said Res #118 has been in this room (the unit's isolation room) for about two weeks upon being transferred from the fifth floor.	4 125	RECEIVED 2017 OCT 16 P 3:05 STATE OF HAWAII DOH-OHCA MEDICARE Res#118 Director of Nursing (DON), Nursing Supervisors (SRN), head nurses (HN), licensed nurses (LN), and the interdisciplinary team (IDT) will implement corrective actions for R #118 affected by this practice, including: 1. In accordance with Leahi Hospital's policies and procedures, each resident will be treated with dignity and respect at all times. For R#118 the personal privacy situation was addressed immediately by instructing the CNAs and LNs to put a sheet over the resident's body, close the doors, and put up a screen to provide privacy during the resident's care; a permanent privacy curtain was installed the next day. The DON also instructed the CNAs and LNs to prevent exposure of the resident's entire body by keeping all areas of the body covered other than those requiring care during ADL.	8/22/17

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO/ADMINISTRATOR — (X6) DATE: 10/12/17

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4 125	Continued From page 1 The Director of Nursing (DON) and the unit's nurse manager, Staff #59, also came to the room and saw the resident lying naked on her bed and exposed to full public view. At 9:50 AM, Staff #40 confirmed the resident has been in this room for about two weeks but had asked for curtains to be put up. Staff #40 said, "the regular (staff) in here asked housekeeping," but to date she said nothing was provided. The DON stated they needed to do something right away to Staff #59. The DON affirmed Res #118 was not afforded privacy of her body during personal care and was exposed to public view.	4 125	2. The DON, SRN, HN, and IDT will identify residents that could be affected by this practice, and will make daily rounds to ensure that the privacy and dignity of all residents are maintained at all times. 3. The DON and Administrator have in-serviced caregivers and staff from other departments to ensure that they report any practices or activities that could adversely affect a resident's privacy or dignity immediately after observing them. A Stop and Watch communication program was initiated to ensure immediate response and reporting of any abused/neglect warning signs. Staff will be re-educated to ensure that they understand the requirements for personal privacy and dignity. The environmental committee will continue to make rounds to ensure that all resident' rooms are provided with privacy curtains. Reinforce staff to initiate Maintenance Work Order Request to immediately address environmental concerns. 4. The SRN and HN on all shifts will monitor each resident in their area of responsibility on a daily basis to identify privacy concerns and communicate them to the DON and Administrator. The quality assurance performance improvement (QAPI) committee will provide oversight to ensure proper monitoring of privacy and dignity-related issues for all residents.	08/22/17 8/22/17 and ongoing 8/22/17 and ongoing
4 131	11-94.1-29(b) Resident abuse, neglect, and misappropriation (b) All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source or origin, and alleged misappropriation of resident property shall be reported immediately to the administrator of the facility, and to other officials in accordance with state law through established procedures. This Statute is not met as evidenced by: Based on observation, interviews and review of the facility's policy and procedure, the facility failed to ensure that all alleged violations involving potential abuse and neglect, including injuries of unknown origin are thoroughly investigated with evidence of it for 1 of 32 residents (Res #116). Finding includes:	4 131		

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4 131	Continued From page 2 1) Res #116 was found to have sustained multiple fractures from an unwitnessed fall on 11/14/16 at 7:30 PM. As a result of this fall, she sustained six right rib fractures, a comminuted fracture of the right midclavicle, and a right radius fracture. The facility submitted their completed event report form (ERF) to the State Agency (SA) on 11/15/16. On 8/15/17, a family interview was done as this resident remains in the facility and was in the Stage 1 sample. The family member stated in response to the staffing and notification of change questions that this facility did not have enough staff. He/she stated Res #116's fall was because "the staff was not there to answer (resident's) call light and she ended up being hospitalized with a wrist, collarbone and rib fractures." The family member stated Res #116 told the family she called to get up to go to the bathroom, but no one responded. The family member said for the bed alarm, "We could be there and pretty much standing her up, but no one would come. So why have a bed alarm when no one comes? So this one night she called, no one came so she tried to get out of bed on her own to go to bathroom and she fell. So that night we got a call that (resident) fell and they said they're going to monitor her. No, she suffered through the night with all these broken bones and after all of that, (another family member) goes over the next day and she's in all this pain and they downplayed it but said that she may have fractured something but it's up to you folks if you want to call 911 and take her to the hospital because we're not." The family member stated the resident was taken to a nearby hospital where she was admitted and then later returned back to this facility. The family member said only upon readmission to the facility was she moved	4 131	Res#116 The DON, Administrator, SRN, HN, and IDT immediately reviewed state requirements for reporting and investigating potential abuse, neglect, and injuries of unknown origin, and will implement corrective actions to ensure compliance with these requirements: 1a. The H.N (Staff #59) was re-educated and counseled to ensure that she follows the proper protocol and procedures for reporting, investigating, and documenting incidents and violations involving potential abuse, neglect, and injuries of unknown origin (such as falls). HN was given appropriate personnel action emphasizing thorough investigation by interviewing all involved staff to determine causal factors and/or rule out abuse/neglect. 1b. Staff #142 received review of expectations of license nurse to do post fall assessment for injuries / fractures by examining / palpating chest, pain assessment, completing post fall nursing observation flow sheet (post fall monitoring of neuro checks and patient condition), documenting on medication administration record after administering Tylenol, and documenting on the progress note about resident's fall. 1c. Staff #106 received review of expectations of license nurse to do post fall monitoring, documentation (post fall monitoring of neuro checks and patient condition), and notification of MD when residents pain increased significantly.	8/22/17 9/14/17 completed 9/14/17 completed

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4 131	Continued From page 3 closer to the nurse's station. The family member said, "Here's a 101 year old woman that was saying she wants to die because of it--and I thought that was just really unnecessary that she had to go through all that." She also recalled being told the night of the fall from a staff who called that she did not need to come to the facility because they would be addressing resident's pain with Tylenol. The family member expressed because of what had transpired, and the way things were communicated to them, another family member has been vigilant about visiting the resident almost daily and believed this has helped to keep staff more aware of the resident's needs. On 08/15/2017, review of the ERF submitted by Staff #59 was done. Staff #59 was asked whether her completed investigation included documented interviews of staff who worked the night and morning of 11/14 and 11/15/16. On 08/16/2017 at 10:44 AM, per the DON, she said with Staff #59 standing next to her, "There is no written investigation of the staff involved. Unfortunately she did not do a follow-up." Staff #59 was asked how then did she conclude on the ERF that no abuse/neglect was found given for a 101 year old resident with an unwitnessed fall and multiple fractures requiring hospitalization. Staff #59 said, "It was whatever staff gave me information verbally. Yes, that's how I completed the report." She confirmed she had no documentation of witness statements. Review of the facility's policy and procedure, "Prevention of Resident Abuse, Neglect,...", Policy No. LPAT0003, eff. 1/01/09, it stated, "I. Purpose B. To report and conduct a thorough investigation of all incidents and provide appropriate corrective actions and preventive	4 131	2. The DON formed a Process Improvement Project (PIP) committee to review all incidents, evaluate their root causes and identify residents at risk for falls or other injuries. The PIP committee will develop and implement a checklist for completion of required documents upon submission to DON for these types of incidents. Form 209 was reinstated for staff to write their statements for falls events to explain what happened. 3a. The Fall Prevention policy will be revised to reflect Measures for preventing falls and other incidents will be implemented and documented in the resident's care plan. These measures may include providing lower beds, non-skid footwear, and improved bedside mats to lessen impact in case of fall from the bed. For residents that get up because they are unable to sleep, measures such as decreasing noise during the night, and other means of enhancing the resident's comfort may be implemented. Staff has been in-serviced on the management of residents at risk for falls. The PIP committee meets weekly to evaluate and revise individual care plans. In addition, the number of nursing staff will be re-evaluated and increased if necessary to ensure compliance with the required protocol.	8/22/17 and ongoing 8/22/17 and ongoing

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4 131	Continued From page 4 measures...III. G. NEGLECT means failure to provide goods and services necessary to avoid physical harm, mental aguish or mental illness...IV. Procedure B. Step 3. Assessment & Complaint Documentation 1. Staff shall complete an Event Report form to document the initial complaint and/or witnessed information, including a list of personnel on duty or pertinent witnesses...3. The Charge nurse will perform a physical assessment of the resident and document findings in the resident's medical record. 4. The DON or designee will gather further information and begin a confidential folder. 5. All documentation including preliminary reports to the State agencies will be routed to the Administrator. C. Investigation...3. a. Review the resident's medical record...b. Review the background information...c. Review records of work schedules and staff and resident assignments...e. Conduct and document all necessary interviews with staff, witnesses, resident...g. Submit a written report to the Administrator detailing findings and recommendations..." The SA's on-site investigation of the resident's fall included the following: a) On 08/15/2017 at 2:39 PM, an interview with Res #116 was done in Japanese by the surveyor. The resident is an alert 102 year old resident who was able to reply back in Japanese. She said she used to be able to walk before but once she became bedridden, she has been unable to walk. She did not recall the fall in November 2016. She denied being in any pain at this time. She said one family member visits her every day and said she's uncertain what each day brings when she awakens. b) On 08/16/2017 at 1:58 PM, a telephone	4 131	3b. The following post fall expectations with licensed nurses: Immediate notification of SRN/DON, thorough assessment of resident such as examining and palpating affected areas to rule out injury/fractures, monitoring and documenting resident's condition such as neuro checks, pain assessment and change in condition, and notify MD as significant changes occur, family notification of fall and completion of staff interviews and supervisor evaluations. Initiate review/revision of CP to prevent falls. The PIP committee meets to evaluate events using the root cause analysis, completion of required documents. 3c. A Rapid Response Rule policy and procedure was developed to address significant changes in resident's condition where immediate assessment and prompt notification of MD will be required. 4. Senior management, including the Medical Director, Administrator, DON, SRN, and QA will monitor corrective actions to ensure the effectiveness of the measures outlined above, including spot checks on all shifts to ensure that all staff understand and follow the procedures as required by each individual care plan.	8/22/17 and ongoing 10/17/17 and ongoing 8/22/17 and ongoing

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4 131	Continued From page 5 interview of Staff #141 was done. She completed the SBAR fall event report as she was the licensed nurse on the 11/14/16 evening shift when Res #116 fell at 7:30 PM. She stated while she passed medications that night she heard a loud noise and when she went to check on the resident with a CNA, they found Res #116 on the floor lying on her side. Staff #141 recalled the resident "talking and she said she likes to use the bedside commode at that time and the commode to one side, but tipped over. She was on the ground by bedside. So we needed to assess her, get her up, back to bed, check vital signs, neuros, and I called the doctor and he told me to continue check neuros and I called family to let them know about the incident. I asked if she's in pain, and she said she was in pain, but sometimes she says no, but she was able to help us, able to move her extremities." Surveyor asked Staff #141 what did you do, range of motion? She replied, "I checked her leg if able to bend it, extend it." What about the right side? Staff #141 replied, "She's able to move her hand." Throughout the night? Staff #141 replied, "Uh-huh. And I even check on her and able to grab my hand, squeeze my hand. She cannot really tell me 1-10, can speak simple English too." Staff #141 said, "she's not frowning, no moaning, no crying, so I assuming she's comfortable because she didn't show any signs of pain. I am not sure if I gave--I can't remember too much because I'm a floater." Did you send her out? Staff #141 replied, "I think not." Did anyone else interview you about this? Staff #141 replied, "I think my head nurse actually asked me about the incident. I don't know what happened to (resident). I just heard from there that this patient was sent out. So I don't know exactly what happened, if it happened on my shift. No, nobody followed up with me. When I give the report,	4 131		

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4 131	Continued From page 6 (Staff #59) asked me what happened and I told her what happened." Did this patient use her call light? Staff #141 replied, "That time I couldn't remember for sure if she used the call light." Did you hear an alarm or anything? Staff #141 replied, "I cannot remember if there's alarm." What was staffing that night? Staff #141 replied, "Uh, I cannot recall, but just to tell you the truth, most of the time we are short of CNAs, but the CNA really assigned to this patient was on break. So the other CNA (Staff #99) was the reliever because 1 person will go break and the other CNA is the reliever. Four CNAs split two and two each side, but only one licensed. I'm the only RN for 38 residents. This is on Young 5 at the time." Staff #141 recalled speaking with a family member to let them know their policy and procedure was to call as well as the doctor. Staff #141 was asked for a 101 year old resident with a fall, did she consider sending the resident to the ED? She replied, "We can consider that too, but she didn't have any signs of fracture and I didn't really realize she need to go to the emergency at that time and I continued to check her neuros and pain at that time. My shift ended at 11:30 (PM) and then every time I go home, I reported to incoming shift about her fall and continue to monitor." Staff #141 was asked what the purpose of the bed alarm was for this resident. Staff #141 replied, "For us to know if patient gets up, to go and check the patient for their safety. So everytime, I was passing medicine and close to that room, one door away so I heard the loud noise, so if the call light is on, I will drop everything and answer the call light, because if she does press call light, i could have been there and help her right away." Have there been falls because short staff? Staff #141 replied, "Yeah i think it's a factor too, because we cannot help it, we have to help the resident from falling. I need	4 131		

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4 131	Continued From page 7 to drop what I'm doing to help the patient who is falling. One person falls down, it will hold me up so I'm trying my best to help the aides--especially the restless patients. We understand staffing get enough, but we have sick calls, so that's how ended up being short." Note: Record review found Staff #141 did not do neurological checks, failed to initiate and document the resident's pain level, etc. Cross-reference to findings at F309 and F323. c) On 08/16/2017 at 2:25 PM an interview of Staff #59 was done. She said for her investigation and ERF report to the SA, she did not do any interviews of the staff who worked the night and morning shifts of 11/14/17. She stated she did not have any documentation other than the ERF and the root cause analysis (RCA) form regarding Res #116's fall. The RCA was reviewed and Staff #59 was asked to explain it. She stated, "I try to determine what caused the fall. So the cause is toileting, maybe she wasn't checked or toileted before this happened and maybe she tried to stand up and this happened. When I did interview with them this is what I found out that she was found with urine and BM in her diaper. So, the recommendation is prompted toileting, which means CNAs have to check her every 2 hours and check if she's incontinent or to use the bathroom." Staff #59 said she completed this on the next day, 11/15/16. Staff #59 was asked what other things would have been considered in doing the RCA, and she replied, "Consider environment, lighting." What about your staffing at that time? Staff #59 replied, "Less supervision when there's less staff." Surveyor asked if she was aware that one CNA had been on break when Res #116 fell. Staff #59 said, "Yes. I missed that." She also confirmed Res #116 was able to ambulate prior to	4 131		

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4 131	Continued From page 8 the fall, but after the fall, "she is unable." d) On 08/16/2017 at 2:48 PM, an interview with Staff #99 was done. She recalled on the evening shift of 11/14/16, she came to the aid of Res #116 who had fallen. She recalled coming off her break. She said they did not hear the resident's call light when she went to aid the resident. She said Staff #141 assessed the resident, "and after that the two of us asked other staff and she came to help us and we picked her up and we took her to the bathroom." Staff #99 was asked to clarify this and said, "So two of us carried her (resident) into the wheelchair and took her to bathroom toilet." Staff #99 said the resident was not soiled at all when they found her on the floor. She said the resident actually sat on the toilet, not the bedside commode. Then afterward they put the resident back to bed. Staff #99 said she did not think the resident was in any pain, "Because she was able to handle it, seems it was fine. And then after that the charge nurse took over." Staff #99 stated she was not interviewed by anyone after this incident nor wrote an account of what happened. Staff #99 said she spoke to the charge nurse only but not to Staff #59. Staff #99 also recalled their staffing that evening prior to resident's fall. She said, "We are four that day and we are good for that. But it falls under during the break, but I was there close by to respond." Staff #99 was asked if the resident was ambulatory before the fall and she replied, "The resident was able to stand up and assist before the fall." Note: The SA found the ERF submitted to the SA stated the resident had been found on the floor incontinent of urine and bowel. Staff #99 also stated she did not speak to staff #59 after this incident. e) On 08/17/2017 at 7:00 AM, interview of Staff	4 131		

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4 131	Continued From page 9 #106 was done. He said he was familiar with Res #116 and verified his nursing entry of 11/15/16. Staff #106 stated he worked the night shift and recalled at first the resident had no pain. "But at 1:45 AM she complained of pain. Pain to her right side." He did not fully recall the details of the fall, but stated, "I want to test if the Tylenol gonna work" and felt it was effective. He verified it was his sole entry on the Pain Monitoring Flow Sheet. Staff #106 said Res #116 told him verbally what her pain was. "I let her describe from 1-10. Can you rate your pain from 1-10, 10 being the most painful and 0 being no pain. And she said 9. She's a times 2-3 (alert) and there are some occasions that she's confused." Staff was asked if he would have used the PAINAD scale for her. He replied, "No, I wouldn't use that one for her because she's really conversant at that time and can tell me." He said that scale was used "for those with dementia those who cannot really verbalize." He stated the nurses are supposed to use the Pain Monitoring Flow Sheet. Staff #106 was asked if Res #116 was able to use her call light, and he replied, "Yeah, she's the one who use her call light. Even if she wants to be changed already, she calls. Sometimes she requests water. She can really verbalize her needs. Prior to the incident, she could walk." He repeated, "She does use her call light. Even with turning she helps." Note: Record review found Staff #106 also did not follow the nursing observation neurological checks as there was no documentation found by either Staff #141 and #106. In addition, the ERF completed by Staff #59 mentioned "unable to rate pain using the PAINAD." Staff #59 was asked why she wrote, "Unable to to rate pain using the PAINAD" on the completed ERF, as she stated she would not have considered using it for this resident. Staff #59 said she did not remember why she put it in	4 131		

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4 131	Continued From page 10 there. She acknowledged the PAINAD scale is used for those residents who are with severe to advanced dementia. This resident scored a BIMS of 12 and was able to self-report her pain. f) On 08/17/2017 at 10:14 AM, a re-interview of Staff #59 was done. She stated she recalled on the day Res #116 was transported out to the hospital, she spoke to family members. She said, "I explained to them she's in a lot of pain so that's why transferring out." She could not recall if the family members had questions about the fall injuries after the mobile x-ray was done. Staff #59 could not recall if she even saw the results. "Like I said we were busy transferring patients down to this unit. But every time we have tests like this, I do want to see it and make sure we call the doctor...Yes now I remember. I wanted to call the doctor, for the abnormal results. I talked to the family and the doctor and the doctor wanted to order some type of narcotic pain medication. No, the family just wanted her to go to the hospital already." Staff #59 was asked why was there such a lag time before the ambulance was called, especially since Staff #59 stated she was in a lot of pain. She replied, "I cannot recall anymore, yes, she was only getting the Tylenol." She was asked why there was no on-going clinical documentation about the resident's condition. Staff #59 stated, "Only whatever my charge nurse wrote is it." Staff #59 stated, "Yes, it is a significant fall with fractures." She was asked if her investigation included ruling out the potential for abuse and neglect. She replied, "Oh yes, if unusual situations like this. I did talk to the CNAs that were working that evening, but because I didn't go deeper. I should have. You really need to find out how did it happen and what the situation was,	4 131		

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4 131	Continued From page 11 what was the resident doing at the time and even prior to the event report." However, she affirmed she had no documentation except for the RCA she prepared. She was asked again, if she even considered neglect given the extent of the resident's injuries and the staffing for the evening. She replied, "Oh yes, yes. I think so. Well resident is alert and she can ambulate and if she was checked before that, then maybe it could have prevented the fall. But then again the staffing, we only had 3 CNAs that time. But the thing I know is one CNA was helping the RN already." Staff #59 was asked whether the night shift supervisor was involved in this at all, and she replied, "No mention of it. Because even when I talked to the RN, she should have sent her out already because she was in pain." Staff #59 said when she looked at the record, she felt the resident should have gone out and not waited until the next morning. "I could have expected the evening shift, the time it happened, I told her that, my charge nurse, you should have just sent her out already. I'm not sure she remembers, but I told her that, yes." Staff #59 verified after reviewing the resident's record, the 11/14/16 evening charge nurse who found the resident on the floor failed to initiate and document on: 1) the Nursing Observation Flowsheet, 2) the Pain Monitoring Flow sheet, 3) the Medication Administration Record after administering Tylenol, and 4) document a progress note about the resident's fall at 7:30 PM and prior to leaving her shift. Staff #59 also said she would not have considered using the PAINAD scale for this resident because, "she's alert and this one only for those that are confused. I told her why did you not send her out." g) On 08/21/2017 at 8:17 AM, during another	4 131		

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4 131	Continued From page 12 interview with the DON and Staff #59, the DON agreed the RCA was not done as it lacked an in-depth review to see what the antecedent factors preceding the resident's fall may have been, which staff were present and whether was there enough staff available at the time this resident wanted to be toileted, as well as what their witnessed and documented accounts were. The DON reiterated, "This was not done." Staff #59 also confirmed that Staff #141 was supposed to have documented a follow-up note. She stated she expected a physical assessment to have been done by Staff #141, but said there was nothing documented about it. On 08/21/2017 at 8:47 AM, the DON and Staff #59 re-verified the neurocheck flowsheet was not done by Staff #141 and also failed to initiate a pain monitoring flowsheet and complete her documentation on the MAR for the Tylenol she gave to the resident at 8:50 PM on 11/14/16. h) On 08/17/2017 at 06:40 AM, Staff #129 said the nurse who sent the resident to the hospital on 11/15/16 was unavailable for interview as she was out on extended leave. Thus, for this resident who sustained numerous physical injuries, declined in her functional ability to walk, coupled to a lack of a thorough investigation to rule out neglect, the facility failed to ensure this resident was provided the necessary care and services. This is further evidenced by the lack of clinical documentation by the licensed staff regarding the fall, no neurocheck flowsheet, no on-going pain monitoring and an incomplete RCA. By the time resident was discharged to the hospital, the documentation only included Staff #106's entry, the x-ray result of 11/15/16 at noon, one vital sign entry on 11/15/16 at 2:20 PM and the	4 131		

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4 131	Continued From page 13 discharge/transfer note of 11/15/16 at 3:15 PM.	4 131		
4 135	11-94.1-29(f) Resident abuse, neglect, and misappropriation (f) If the alleged violation is verified, appropriate corrective action shall be taken to protect the resident's safety as well as other residents in the facility. This Statute is not met as evidenced by: Based on observation, record reviews, interviews and review of the facility's policies and procedures, the facility staff failed to report a resident-to-resident incident that involved one resident taking another resident's cap (Res #71 and Res #12). Finding includes: On 08/14/2017 at 12:18 PM during the lunch observation in Young 4 unit's solarium, Res #71 was observed to deliberately snatch the baseball cap off of Res #12's head while they were sitting at their table. The CNAs were passing the trays and no staff were in the room at the time. The meal cart had come up at approximately 12:09 PM. Once Res #71 put the cap on his head, another resident yelled out if he felt better having done that to Res #12. Then Staff #40 came into the solarium and saw Res #71 wearing Res #12's cap and asked him to give it back several times. Once he complied, Staff #40 took it and placed it back onto Res #12's head. (Res #12 is unable to fend for himself as he requires assistance in eating and has a medical history of a stroke and [redacted].)	4 135	Res#71 The DON, Administrator, SRN, HN, and IDT immediately reviewed state requirements for reporting and investigating potential abuse and neglect, and implemented corrective actions to ensure compliance with these requirements including: 1. R #71 was observed to deliberately snatch the baseball cap off R#12' head while sitting at their table. The following measures were immediately implemented for the safety of the residents involved, as well as other residents: -Ensured that dining room services are supervised at all times. -Immediately initiated an Event Report to document the altercation between the two residents. Completed the required reports for State agencies including the Office of Health Care Assurance (OHCA) and Adult Protective Services (APS).	8/22/17

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4 135	Continued From page 14 Staff #40 then stated, "That's why I give you another table" and brought in an overbed table and moved Res #71 away from Res #12. However, Res #71 then reached out to grab Staff #40 and/or made hand gestures of "come, come" to her. During this observation, it was found the residents in the solarium were left unsupervised when the meal trays were being delivered from the cart in the hallway. Res #71 was noted to be very mobile while in his wheelchair and his action of removing Res #12's cap was very swift. On 08/16/2017 at 8:00 AM, Res #12 was observed in the solarium having finished his breakfast. There were six residents in there, but there was no staff to oversee the residents. At 8:02 AM, surveyor asked Res #12 how it made him feel when Res #71 took off his cap. He stated, "piss off," and closed his eyes. On 08/16/2017 at 6:50 AM, the DON stated based on what occurred between the two residents, they initiated an event report to the State Agency. The DON confirmed Staff #39 failed to do an ERF for resident to resident abuse and that Res #71 also tried to grab Staff #40. On 08/16/2017 at 08:10 AM, the unit's nurse manager, Staff #59 said the incident on 8/14/17 had been reported by Staff #40 to Staff #39. Staff #59 said Staff #39 should have written it down, "whatever the observation was that was reported to him." Staff #59 said her expectation was Staff #39, "should have reported it, documented it and done something about it and instructed staff that the two (residents) should have been separated and more intensive." She verified Staff #40 did report it. Staff #59 confirmed and known by staff that Res #71 targeted Res #12's cap. Staff #59 confirmed there was no progress note	4 135	-Reviewed and revised the care plan (CP) for Res#71 to provide room changes as appropriate, plan to address current behaviors with the psychiatrist' input, and develop specific structured plans for periods when the resident is out of bed, e. g., plans for recreational activities andmeal times. Also for the safety of others, a plan to discharge or transition the resident to a less stimulating environment will be developed for his own well-being and as needed to protect other residents and staff (as recommended by his Geri psychiatrist). The family' input was also considered to revise the care plan. -R#12 was interviewed and allowed to express his thoughts and emotions about the incident. The social worker (SW) conducted a follow-up discussion to provide reassurances. R #12 showed no adverse effects after the altercation. The CP for R#71 was revised, and a CP was initiated for R#12. 2. DON, SRN, HN, IDT and Geri-psychiatrist will review all other residents who show potential behavior problems to ensure the safety of all residents and care givers. This includes revising care plans as needed to address behavior problems and ensure that staff have reviewed and understand the procedures required for all shifts. A communication book has been developed to ensure that caregivers on all shifts are aware of the CP changes.	8/22/17 and ongoing

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4 135	Continued From page 15 documentation by the charge nurse that day. Review of the facility's policy and procedure, Prevention of Resident Abuse, Neglect as Policy No. LPAT003, effective 1/1/09, the purpose states, "A. To ensure the prevention, protection, and safety of all residents,...receiving care and services from the facility from incidents of abuse,...and/or misappropriation of property....B. To report and conduct a thorough investigation of all incidents and provide appropriate corrective actions and preventive measures...II. Policy...B. All employees are required to report alleged complaints and/or violations involving abuse, neglect,...and misappropriation of property immediately to the Administrator of the facility...Step 3: Assessment & Complaint Documentation 1. Staff shall complete an Event Report form to document the initial complaint and/or witnessed information, including a list of personnel on duty or pertinent witnesses." The facility's licensed staff failed to implement an initial reporting of a resident-to-resident incident and failed to ensure further procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property was done as verified by the DON.	4 135	3. The DON, Administrator and Social Worker provided a mandatory inservice on Abuse/ Neglect policies and procedures for caregivers. The training covered signs of abuse/neglect, described requirements for further action, and emphasized the need for prompt reporting as outlined in the Stop/ Protect/Oust/Tell/Report (SPOTR) process. A Stop and Watch communication process was initiated to ensure immediate response and reporting of any abuse/ neglect warning signs. Stop and Watch communication will be shared during change of shift reporting. As needed, statements from staff via the F209 (Employee / Resident Quality Assurance Report) form will be acquired for further follow-up process. The DON and designated staff will monitor and ensure that staff report all incidents, observations, and complaints of abuse/neglect, and report compliance to the QAPI committee. 4. The DON and designated staff will monitor and ensure that staff timely report all incidents, observations, and complaints of abuse/neglect and report compliance to the QAPI committee.	9/05/17 completed 8/22/17 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	4 149		

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4 149	Continued From page 16 physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on observations, interviews and medical record reviews, the facility failed to ensure that there were sufficient qualified nursing staff available to meet each resident's needs for nursing care in a manner and in an environment which promotes each resident's highest practicable physical, mental and psychosocial well-being for enhancing their quality of life. Findings include: 1. There is non-compliance with this regulation based on the cumulative deficient findings/outcomes in the various regulatory groupings which include Resident Assessment, Resident Behavior and Facility Practice, Quality of Care, Quality of Life, Nursing Services, etc. The cumulative findings are cross-referenced at their cited regulatory tags at F164, F225, F226, F241, F242, F257, F272, F278, F279, F280, F282, F309, F314, F315, F318, F323, F328,	4 149	Sufficient 24 hour Nursing Staff for Care Plans: Administrator, DON, Senior Management , MD and HR will implement the following corrective actions to address this non compliance to these cumulative findings, by reviewing and revise current nursing organization structure. 1. Not applicable 2. Not applicable 3a. Redirect focus of head nurses to emphasize overall management of patient care and care plans to address individual conditions/needs. Modify HN schedules and, where necessary recruit additional nursing staff to meet requirement of 24 hour supervision/ coverage of patient care. 3b. Initiate annual Facility Assessment from which we will base future training needs and staffing . 3c. Improve clinical competencies at all levels of nursing care (see attached - Annual Check List of Clinical Skills) 3d. Evaluate and revise nurse management coverage to ensure adequate supervision of all clinical staff. 4. Annual resident/family survey, Quality Measures CASPER report, to track improvements and trends and adjust future actions.	10/04/17 and ongoing 10/04/17 and ongoing 9/22/17 and annually 8/22/17 and ongoing (3/31/17) and annual

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4 149	Continued From page 17 F329 and F514. 2. Additional findings include: On 08/14/2017 at 12:09 PM, an initial dining observation on the Young 4 unit was done. Staff #40 said several of the residents sitting in the solarium "needs assistance with eating." At 12:25 PM, Res #12 had his food tray placed in front of him, but it was not until 12:39 PM that Staff #137 starting taking the food off his tray onto a placement. Then she sat next to Res #12 to feed him. In addition, when Staff #59 was asked about the number of residents who required closer supervision, cueing and/or feeding assistance on this unit, she stated she had the most. The list she provided included 14 total residents for feeding assistance. Staff #59 acknowledged there should be staff in the solarium to supervise the residents, when there was none. Staff #59 then queried the surveyor and asked, "How do the other facilities do it?" It was found the residents in the solarium were left unattended with many of them requiring feeding assistance by staff who were not available to help. For Res #118's in-room dining, it was found that by 1:05:57 PM, her meal tray had been left in her room from the time the meal cart had arrived onto the unit. The resident still had not been fed. The three CNAs available during lunch were busy assisting the other residents to eat in the solarium. At 1:09:08 PM, CNA #137 said, "I'm going to feed her now" and went into Res #118's room. Thus, it took one hour before this resident was assisted to eat. It was also later found during an environmental rounds tour that this resident's room temperature was hot and close to 90 degrees Fahrenheit. Cross reference to findings at F257. Her meal tray had been sitting in the hot, unventilated room for one hour.	4 149	Dining observation: Identify and implement "All Hands on Deck" Meal Assistance 1. Dining room service staff assignments was reviewed for this nursing unit as well as reinforced with staff to address adequate staffing during meals. 2. To prevent this deficient practice from affecting other residents, the dining room staff assignments for all units was reviewed and reinforced to address adequate staffing during meals. 3. Identify those residents that require meal assistance in order to strategize staffing needs. -Accommodate resident dining needs by adjusting employees meal breaks. -Provide additional assistance by identifying other staff that are qualified to assist with various aspects of resident dining. -Stagger resident meal times to help optimize staff coverage. 4. QAPI committee members will perform a monthly dining room observation (QIS) to evaluate resident dining experience report to QAPI committee for recommendations.	8/22/17 8/22/17 10/04/17 and ongoing 8/22/17 and ongoing

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4 149	Continued From page 18 3. Then on 08/15/2017 at 8:28 AM, there were five residents in the solarium but with no staff present. One of the residents began dumping out her thickened juice onto the table with a spoon. Staff #59 observed this when the surveyor asked her to do a concurrent observation. Staff #59 reiterated they have a lot of residents who require feeding assistance. She said although they had their maximum number of CNAs (five), she acknowledged for one other resident (Res #93), her meal was hardly touched. Staff #59 said this resident needs a lot of encouragement as she will not just sit down and eat. Again, there was no staff in the solarium to assist this resident to eat, while the other resident was dumping out her thickened liquid onto the table. There was not enough staff to consistently assist these residents as part of their overall dining experience. 4. On 8/15/2017 during a Stage 1 family interview, the family member for Res #116 stated in response to the staffing and notification of change questions, that this facility did not have enough staff. He/she stated Res #116's fall was because "the staff was not there to answer (resident's) call light and she ended up being hospitalized with a wrist, collarbone and rib fractures." The family member stated Res #116 told the family she called to get up to go to the bathroom, but no one responded. The family member said for the bed alarm, "We could be there and pretty much standing her up, but no one would come. So why have a bed alarm when no one comes? So this one night she called, no one came so she tried to get out of bed on her own to go to bathroom and she fell. So that night we got a call that (resident) fell and they said they're going to monitor her. No, she suffered through the night with all these broken bones and	4 149	Family Member of R#116: 1. Identify those residents at high risk for falls or recurrent falls in order to prioritize resident needs. 2. Reinforce need for staff to promptly respond to resident call lights and to anticipate their needs. 3. Identify those residents at high risk for falls or recurrent falls in order to prioritize resident needs. Reinforce need for staff to promptly respond to resident call lights and anticipate their needs. MD and DON developed a Rapid Response Rules Policy and Procedure, to emphasize requirement for licensed nurses to recognize, evaluate and respond to resident changes in condition, such as falls with major injuries. (see attachment of RRR policy and Check list). Inservice training on Person Centered Care will be done. (refer to Code of Conduct). 4. Annual Resident Survey will monitor improvements and trending.	8/22/17 8/22/17 8/22/17 and ongoing (3/31/17) and annual

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4 149	Continued From page 19 after all of that, (another family member) goes over the next day and she's in all this pain and they downplayed it but said that she may have fractured something but it's up to you folks if you want to call 911 and take her to the hospital because we're not." The family member also expressed that because of what had transpired, and the way things were communicated to them, another family member has been vigilant about visiting the resident almost daily and believed this has helped to keep staff more aware of the resident's needs. 5. On 08/16/2017 at 1:58 PM, a telephone interview of Staff #141 was done concerning the care she provided for Res #116 on the evening of 11/16/17. During her interview, she stated in response to what the staffing was that evening, "Uh, I cannot recall, but just to tell you the truth, most of the time we are short of CNAs, but the CNA really assigned to this patient was on break. So the other CNA (Staff #99) was the reliever because 1 person will go break and the other CNA is the reliever. Four CNAs split two and two each side, but only one licensed. I'm the only RN for 38 residents. This is on Young 5 at the time." And despite the fact she stated in her interview that she continued to check the resident's neurological status and her pain, these were quality of care areas which were found not have been done due to the lack of clinical documentation. Additionally, Staff #141 acknowledged that being short of staff, ""Yeah I think it's a factor too, because we cannot help it, we have to help the resident from falling. I need to drop what I'm doing to help the patient who is falling. One person falls down, it will hold me up so I'm trying my best to help the aides--especially the restless patients. We understand staffing get enough, but we have sick calls, so that's how	4 149	Staff Interview of R#141: 1. DON will confirm and validate staffing concerns through staff interviews and discuss their perceptions regarding staffing issues. 2. Assess resident needs and provide specific training on monitoring residents with dementia, behavior issues and residents with high risk for falls (Hand in Hand Dementia Training). 3. Use facility assessment to determine possible variations in staffing needs based on residents acuity. 4. Annual Resident Survey will monitor improvements and trending.	8/22/17 and ongoing 10/17/17 10/04/17 and ongoing (3/31/17) and annual

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4 149	Continued From page 20 ended up being short." 6. For the fall incidents related to Res #116, #38 and #114, the facility failed to ensure they reviewed the staffing patterns and failed to complete thorough root cause analyses of their falls, albeit the residents sustaining serious physical injuries.	4 149	Fall Incidents: 1. For residents #116, #38 and #114, the Performance Improvement Project team met with involved staff to perform a root cause analysis, based on their findings the care plans for these residents were revised. 2. Performance Improvement Project Team, including DON and Unit Managers, will perform root cause analysis on all falls going forward.	8/22/17 8/22/17 and ongoing
4 152	11-94.1-39(e) Nursing services (e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures. The policies and procedures shall include but not be limited to: (1) Written procedures for personnel to follow in an emergency including: (A) Care of the resident; (B) Notification of the attending physician and other persons responsible for the resident; and (C) Arrangements for transportation, hospitalization, or other appropriate services; (2) All treatment and care provided relative to the resident's needs and requirements for documentation; and (3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized	4 152		

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4 152	Continued From page 21 This Statute is not met as evidenced by: Based on observations, medical record reviews (MRR) and staff interviews the facility failed to ensure that 3 of 32 residents (R#38, R#116, R#46), obtained optimal improvement and/or did not deteriorate within the limits of their recognized pathology and the normal aging process, and, each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in the Stage 2 sample. Findings include: 1) On 08/15/2017 at 2:39 PM, Res #38 was observed in bed with her lower legs uncovered. It was found her right lower shin area had a dressing applied to it and her left shin area had a large bruise-like area to it. The resident is non-interviewable. On 08/17/2017 at 12:53 PM, record review found Res #38 was readmitted to the facility on 4/18/17 after a hospital stay post-fall. Her initial skilled nursing admission record however, found she was originally admitted on 7/25/13. In the 2013 clinical record, there was documentation showing resident's "BLE (bilateral lower extremities) with small faded bruises" was assessed, but without baseline measurements. During an interview with Staff #59 and Staff #72 on 08/17/2017 at 1:21 PM, Staff #72 said the resident does not have bruises, but that it was her usual skin discoloration. She stated, "has been that way ever since she was here--years. She was on aspirin before but not anymore ever since she developed a hematoma. Always had the discoloration, but it's her skin that's discolored,	4 152	Res#38 1. Doppler ultrasound was completed and MD documented the cause of the discoloration and care planned. 2. House-wide skin assessments were done by Medical Director, HNs and DON. Any conditions and abnormalities were documented and care planned. 3. CNAs are doing daily STOP and WATCH and report to the licensed staff. The licensed nurses will make appropriate referrals to vascular surgeons, podiatrists, dermatologists, and wound clinic. Will hold weekly rounds and evaluate the treatments for its effectiveness and submit a weekly report to the DON and Medical Director. Medical Director will be consulted on selected patients as needed. LNs will be trained to provide consistent assessments properly characterizing wounds, promote proper skin care, prevention of skin breakdown and wound management. We will review and revise current policies and procedures with guidance from a wound care specialist educator to ensure that we provide proper care for wound prevention and treatment based on the most current standard practices. We will hold weekly meetings with the PIP team. Also a "weekly wound ulcer reporting" form will be developed and used to promote communication between all team members involved in the resident's care. 4. DON, SRN, HN and QA will do monthly care plan review for all residents with wounds. Findings will be reported at QAPI committee for further recommendations. Medical Director will conduct spot checks.	8/22/17 10/17/17 and ongoing 10/17/17 and ongoing 10/17/17 and ongoing

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4 152	Continued From page 22 but no swelling or anything...She was with us, went to another floor, and then came back to us. Her shins have been like that for awhile." Both staff were queried with the resident's readmission, if a baseline measurement of the bruising or "discoloration" which their nurses have been documenting since 2016 in the progress notes was ever done. They reviewed the 2013 skin assessment note that showed the same leg areas with only "small faded bruises." Staff #59's reply was, "When she came back, we knew she already had that, but it should be somewhere in the older record." Staff #72 said, "Myself, I never measured it, but has always been her whole shin area, right down here." Both staff were further queried if a readmission baseline skin assessment was not done, how could nurses, therapists, etc. determine whether Res #38's skin condition was improving or worsening, and/or what changes were actually being monitored for. Staff #72 said as nurses they see the resident every day so they can tell if it's an old discoloration versus a new bruise. When surveyor again asked if this monitoring is being done, when did the resident's bilateral lower extremity skin condition change from being small faded bruises to a larger discoloration. Finally Staff #59 was asked, "Where's your baseline measurement for this discoloration? There is none?" Staff #59 nodded affirmatively that there was none. On 08/17/2017 at 1:21 PM, per Staff #59, she said resident's skin discoloration "has been that way ever since she was here--years." She was on aspirin before but not anymore ever since she developed a hematoma. Always had discoloration, but it's her skin that's discolored, but no swelling or anything. She was with us,	4 152		

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4 152	Continued From page 23 went to another floor, and then came back to us. Her shins have been like that for awhile. On 08/17/2017 at 1:39 at PM, the DON said Res #38's weekly skin assessment shows bilateral old bruises, but no baseline documentation for it. On 08/17/2017 at 3:00 PM, during the infection control task meeting, Staff #115 and another licensed staff stated for wounds, skin conditions, etc., for Res #38 bilateral lower extremities, the nursing staff should have baseline measurements. They concurred it was basic nursing practice to do so. On 08/21/2017 at 7:59 AM, the DON told Staff #59 she wanted Res #38's legs to be covered with leg protectors and whether there were issues with positioning of the resident. Staff #59 said the attending physician did not know about the lower leg extremity and although nursing has been "monitoring" it all this time, Staff #59 said the attending physician has never documented on it. The DON asked, "what's causing all this? If (attending physician) could only write and do a consult. So all this time..." The DON expressed, "I want them to further look at the area, the condition of the affected area. So protection of skin to prevent from breakdown. Go beyond the assessment, yeah. Then of course we want to know the cause of this." On 08/21/2017 at 9:00 AM, surveyor asked the DON to clarify the 8/17/17 measurements obtained by her nursing staff. It had stated, "Left leg shin area with discolored measured: Length 29 cm and width 9 cm. Photo taken per..." The DON said this skin assessment was not acceptable. The DON and two other licensed staff went to re-do the skin assessment to obtain what would be the initial baseline measurements.	4 152		

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4 152	Continued From page 24 The DON provided this revised 8/21/17 skin assessment which stated, "Resident with brownish discoloration to Lt leg shin measuring 24.0 cm x 9.0 cm with small dark bluish discoloration (dime-sized) approx 1.0 cm x 0.75 cm within the brownish discolored area on upper lateral lt. shin and another reddish discoloration approx. 3.0 cm x 1.0 cm within the brownish discolored area on lower lt. shin. No swelling or erythema; resident denies pain or discomfort." The DON acknowledged the size of it was pretty large. It was pointed out the 2/28/17 photographs of resident's left lower extremity showed what appeared to be macerated skin with open areas. Yet, there were no measurements and the photographs were pictured on a totally blank wound care measurement and assessment form. In addition, surveyor pointed out the original 7/25/2013 documentation noting the resident was admitted with bilateral lower extremities small faded bruises was not what was assessed to be her current status as evidenced by the wound measurements obtained on 8/21/17. Thus the facility failed to ensure Res #38's skin condition had noticeable optimal improvement as there was no concise assessment starting with basic measurements of its size to know what, if any, were related to recognized pathology and the normal aging process versus an injury or unknown origin. 2) Res #116 sustained multiple fractures after she fell on 11/14/17. On 08/21/2017 at 8:47 AM, the DON and Staff #59 verified the neurocheck flowsheet was not done by Staff #101 and she also failed to initiate a pain monitoring flowsheet and complete her documentation on the MAR for the Tylenol she gave to the resident at 8:50 PM on 11/14/16. Cross-reference to findings at F225,	4 152	Res#116 1. DON re-educated HN #59 and staff #101 regarding the proper post-fall monitoring, including completion of neuro checks, pain flow sheets, and basic medication documentation. 2. PIP Committee reviewed all recent falls for completeness of documentation such as pain flow sheets, neuro-checks, medication documentation and care plans. Staff were re-educated for any deficiencies that were identified.	9/14/17 8/22/17 and ongoing

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4 152	Continued From page 25 F323 for Res #116. 3) On 08/15/2017 2:17:02 PM, the MRR on R#46 found that the resident was admitted to the facility on 04/17/17 for respite care with approved form 1147 (authorization request) for 29 days (04/17/17 to 05/15/2017). The level of care (LOC) evaluation form(DHS 1147) notes that R#46 primary diagnosis included: status post tracheotomy, gastronomy, and quadriplegia. The resident was assessed and determined to have complete absence of speech, unable to communicate wants/needs; disoriented (partially or intermittently)required supervision; tube fed; did not assist in transfer or is bedfast; unable to walk; incontinent; cannot bathe without asst; requires total help in dressing, undressing , and grooming. The required skilled procedures for R#46 were: non-ventilator dependent tracheotomy care/suctioning 6 times/day; tracheotomy care; and, therapeutic diet of Jevity 1.2 kcal, 1 can 5 x/day. The skilled procedures for decubitus ulcers (Stage III and above) and decubitus ulcers (less than Stage III); wound care was marked "N" (not applicable /Never). The adult residential care home (ARCH) from where R#46 was transferred from, also faxed over the resident's individualized service plan (ISP), that included, "Impaired skin integrity risk, follow skin breakdown prevention protocol (position, change, keep clean & dry), proper nutrition." On 08/16/2017 at 7:09 AM continued MRR on R#46 and on the long term care facility transfer form dated 04/17/17, documentation included: no pressure ulcers; medications reviewed and renewed on 02/21/17;...Calmoseptine ointment apply to buttock area with each diaper change	4 152	3. DON and HNs in-serviced all staff on prevention of falls and proper assessments and post-fall documentation as well as medication documentation. PIP committee is monitoring all incidents on a weekly basis. 4. DON and QA will report findings at the QAPI committee for further recommendations. Res#46 1. Staff were re-educated that treatment should have been evaluated within two weeks for effectiveness. 2. House-wide skin assessments were done by Medical Director, HNs and DON. Any conditions and abnormalities were documented, followed up and care planned. 3. Weekly wound/skin assessments will include any skin conditions in order to better assess, treat and monitor for better effectiveness and appropriate treatment. LN will be trained to provide consistent assessments, properly characterize wounds, promote proper skin care procedures, and improve care and prevention of skin breakdown and wound management. 4. DON, SRN, HN and QA will review and revise current P&Ps with guidance from a wound care specialist educator to ensure that we provide proper care for wound prevention and treatment based on the most current standard practices. We will hold weekly meetings with the PIP team. Also a "weekly wound ulcer reporting" form will be developed and used to promote communication between all team members involved in the resident's care.	9/14/17 and ongoing 11/2/17 and quarterly 8/22/17 8/22/17 and ongoing 8/22/17 and ongoing 8/22/17 and ongoing

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4 152	Continued From page 26 PRN for skin breakdown." The facility's interdisciplinary admission care plan (CP) dated 4/17/17, for "CP#4 Potential for Skin Breakdown/Skin Breakdown," included interventions of: "Encourage resident to turn every 2 hours or assist resident to to turn every 2 hours; Assess resident's skin every week and document findings; Report skin breakdown to Skin Care Nurse for consult..." The facility's interdisciplinary progress notes dated: 4/23/17, "#4 At risk for skin breakdown," documented that R#46 had a small cut on left side of lip." 4/27/17," #4 at risk for skin break down (buttocks)," the progress notes documented that the resident had 3 open areas on his/her buttock measuring 2 x 1 cm and 1 x 1.5 cm to L buttock; and, 2 x 2.5 cm. Calmoseptine was applied to the area and resident was turned side to side as much as possible. 05/03/17 the wound care nurse documented that "buttock/coccyx breakdown noted 04/27/17; contacted me 05/03/17." The facility's CP dated 4/27/17, problem #4 (SKIN) At risk for pressure ulcers due to limited bed mobility (including inability to reposition self and body parts) and exposure to excessive moisture from fecal incontinence; with measurable goals, "Intact skin on buttocks and perineum without evidence of redness, irritation, or maceration;" goal date 05/29/17. On 08/16/2017 at 8:18 AM interviewed Staff#70 and queried why staff waited 6 days before informing the wound care nurse. The DON stated that the wound care nurse was monitoring	4 152		

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4 152	Continued From page 27 R#46's pressure ulcers and that by the resident's discharge date the wounds were healed. On 08/16/2017 at 10:36 AM a telephone interview of R#46's home caregiver (CG) was done. The CG stated that the resident was placed at the facility for respite care and at the time of discharge back to her care home, facility staff apologized that the resident had skin breakdown at the facility. The CG stated that the resident has been in her care home for 7 years and never had pressure ulcer or skin breakdown. The CG related that resident is incontinent of bowel/bladder and is changed right away when brief is wet to prevent skin breakdown. CG also stated that DOH comes to inspect her care home and in care home records this resident never had pressure ulcer under her care. On 08/17/2017 at 9:13 AM interviewed Staff#98 to discuss R#46's skin breakdown while in the facility. According to Staff#98, the resident's pressure ulcers (PU) were not staged because buttock area has no bone so not considered PU. Staff#98 further stated that R#46 was admitted to facility with calmoseptine ointment and discoloration on resident's buttocks shows that resident had skin breakdown before. Staff#98 diagnosed skin breakdown as incontinence associated dermatitis and not PU. The nursing staff were instructed on how to treat incontinence associated dermatitis (IAD) and may be reason why staff reported skin breakdown to her on 05/03/17 and not on 04/27/17 when discovered. Staff#98 last saw R#46 on 5/08/17 and determined then, that within several days skin breakdown would be healed. The wound care measurement and assessment forms dated: 4/27/17 included a picture of	4 152		

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4 152	Continued From page 28 reddened areas on the residents buttocks, with no exudates and normal wound edges; 5/3/17 included a picture of the L buttock and coccyx, with wound type described as single thickness wound, no exudates, normal wound bed, surrounding skin color, and wound edges. The measurements written at the bottom were, "#1 L butt - 3.0 x 2.0; #2 coccyx 1.0 x 1.0;" 5/8/17 included a picture of the L butt, single thickness 3.5 x 2.0 cm, no exudates, wound bed epithelial tissue, normal surrounding skin color and wound edges. Written at the bottom of the sheet, "coccyx healed." On 08/21/2017 at 2:49 PM the MRR on R#46 found on the Leahi Hospital SBAR REPORT dated 5/3/17; To: R. Gries; From: Y3 Leahi Hospital; Situation/Assessment (SBAR); Resident's buttocks with skin breakdown (excoriation) TX done per Leahi protocol; calmoseptine ointment TID & PRN; Background: DX: Traumatic brain injury; Assessment/Recommendations: Pls assess & any recommendations." The May 17 Physician Orders included, "PRN 4/17/17 Risamine ointment (for Calmoseptine Ointment) apply topically to buttock with each diaper change PRN skin breakdown." The Admission Orders on 4/17/17 included, Calmoseptine ointment topically to buttock each diaper change PRN. The Daily system Assessment Performed (sheets) documented on these dates and times day(D), evening (E), and night (N): 4/17-24/17 skin intact, warm and dry 4/25/17 (D) L buttock denuded calmoseptine apply; (E) L corn of lip scab	4 152		

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4 152	Continued From page 29 4/26/17 Buttocks excoriated on (D,E, N) 4/27/17 D) buttocks excoriated, calasime applies; E) Calazime applied to buttock 4/29/17 Buttocks still excoriated/open areas 4/30/17 D) Buttocks still excoriated, continue to apply calazime; E) buttocks still excoriated calazime applied 5/1/17 D) buttock excoriated 5/2/17 D) buttock still moist, cont reposition Q 2 hr & apply calazime; N) Buttocks remain open The facility did not provide the necessary skin care and services consistently to maintain R#46's skin integrity to prevent IAD.	4 152		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation and interview with staff members, the facility failed to ensure food was stored in accordance with professional standards for food service safety. Findings include:	4 159	Unlabeled Miso Paste- 1. Staff to be re-educated on safe food storage practices. 2. Tracking protocol implemented, whereby all food items, prior to delivery to refrigeration units shall be inspected by Cook II supervisors for p[roper labeling. Log noting date,time,quantity of all items shall be initialed by Cook II's. Prior to the end of each shift, Cook II's shall inspect all refrigerated items to ensure that they are properly labeled. 3. Tracking logs to be audited by Cook III and submitted to Leahi Safety Committee. 4. QAPI committee will review findings and recommendations will be forwarded to the facility Administrator and/or designee for follow up action.	8/22/17 8/22/17 10/17/17 and ongoing 10/17/17 and ongoing

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4 159	Continued From page 30 1) On the morning of 8/14/17 a brief initial tour was done with Staff Member #20. Concurrent observation with Staff Member #45 of the pantry refrigerator found a plastic tub of miso paste that was not labeled. The staff member reported the miso paste was opened on Saturday and will be discarded based on the manufacturer's date. Also observed two small plastic tubs of beef based that was not labeled with an open date and there was one glass bottle of chili sauce that was not labeled with an open date. The pantry refrigerator also contained a partially consumed commercial bottle of water and a flask. Staff Member #20 reported these are personal items belonging to the staff. Concurrent observation was done with Staff Member #20 of the back up refrigerator behind the tray line. Observation found the following: one large plastic container of French dressing with a label indicating to use by 7/7/17; one small squeeze bottle of french dressing that was labeled to use by 8/7/17; and one small squeeze bottle of salad dressing with a label affixed to the side but was not filled out with an open and discard date. Interview and concurrent observations were done with Staff Member #61 on 8/14/17 at 8:45 A.M. The staff member reported food is labeled with the date opened and supposed to be labeled with the date to discard, which would be 7 (seven) days after it is opened. The Manager also confirmed personal items are to be stored in the employee break room, not in the kitchen refrigerators. 2) On 8/15/17 at 11:00 A.M. observed Staff Member #161 wearing gloves and spooning mayonnaise onto bowls of beets. The staff	4 159	Salad Dressings- 1. Staff to be re-educated on safe food storage practices. 2. Tracking protocol implemented, whereby all food items, prior to delivery to referigeration units shall be inspected by Cook II supervisors for proper labeling. Log noting date, time, quantity of all items shall be initialed by Cook II's. Prior to the end of each shift, Cook II's shall inspect all refrigerated items to ensure that they are properly labeled. 3. Staff will no longer prepare homemade dressings. Pre-made commercial dressings shall be purchased and kept until expiration date. Once opened, the containers shall be labeled with 30-day expiration date, per Edwin Jatico from the DOH. 4. Cook II's shall monitor refrigerated dressing containers to ensure they are not kept beyond the expiration date. Staff to be re-educated on safe food storage practices. Cook II supervisors shall monitor all refrigerated items to ensure proper labeling. Staff have been instructed that personal items are not to be stored in the Dietary department refrigeration units.	8/22/17 8/22/17 8/22/17 8/22/17

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4 159	Continued From page 31 member walked to the trash can and lifted the lid to dispose of trash. The staff member did not change his gloves and continued to spoon the mayonnaise on the beets. The staff member failed to change the gloves after touching the trash can lid to preparing food.	4 159	Glove Change- 1. Staff re-educated on proper hand hygiene and use of Personal Protective Equipment. 2. Dietary staff will receive monthly re-education and training by the Dietary Supervisor and/or designee. 3. Tracking log implemented to ensure every employee undergoes demonstration. 4. Periodic Auditing will be conducted by the Dietary Supervisor and/or designee to ensure compliance. QAPI committee will review findings and recommendations will be forwarded to the facility Administrator and/or designee for follow up.	8/22/17 9/15/17 and ongoing 10/17/17 and ongoing
4 173	11-94.1-43(a) Interdisciplinary care process (a) A comprehensive assessment shall be completed for each resident by an interdisciplinary team at least annually and updated as appropriate, based on the resident's condition. This Statute is not met as evidenced by: Based on observations, medical record reviews (MRR) and staff interviews, the facility failed to assess, identify and address physical functioning and structural problems for 2 of 41 residents (R#15 & R#106). Findings include: 1) On 08/16/2017 at 9:03 AM during medication administration for R#106, observed that the residents toes on the right (R) foot had blackened nail beds from the great toe to the 4th toe. The toe nails were long and the great toenail looked slightly lifted with small reddish blisters on the sides of the toes. On 08/16/2017 at 10:23 AM Interviewed Staff#71 and he stated that R#106's skin assessment would be in the electronic medical record (EMR) and that R#71 had a condition that caused blisters.	4 173	Res #106 - The DON, wound care nurse (WCN), SRN, HN, and rehab department will implement corrective actions to ensure that comprehensive assessments are conducted and that all physical functioning and structural problems are addressed. 1. The (WCN) wound care nurse, HN, and licensed nurse (LN) re-assessed and corrected the wound characterization. The CP and interventions were reviewed and revised based on current measurements and wound status as needed to prevent infection and provide the proper treatment. A podiatrist was consulted and provided treatment. R#106 also may be referred to a vascular surgeon for further evaluation. 2. CNAs have observed and reported any skin conditions or contractures to the LNs on a daily basis through the Stop and Watch communication tool. A referral to the Rehab department was initiated. The LNs will be trained to provide consistent assessments, properly characterize wounds, promote proper skin care procedures, and improve care and prevention of skin breakdown and wound management. Rehab department will screen/ assess for ROM on all new admissions/re-admissions.	8/22/17 8/22/17 and ongoing

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4 173	Continued From page 32 On 08/16/2017 at 10:40 AM, Staff# 156 printed weekly skin assessments done on R#106 and all were for an open area on the left buttock with dates of: 8/13/2017, 7/30/2017, 7/23/2017, and 7/17/2017. Staff were unable to find any assessments of the resident's toes on the R foot. Both Staff#71 and Staff#156 went to assess R#106's toes on the R foot and asked the resident if toes were sore. Staff#71 mentioned that R#106 probably had podiatry consult as resident had above the knee amputation (AKA) on the left (L) leg and was diagnosed with peripheral vascular disease (PVD). Staff#71 looked in R#106's medical record and could not find a podiatry consult. Staff#71 then called the podiatrist to ask if there was any record of resident being seen by podiatrist, and the podiatrist did not have any record on R#106. 2) On 08/17/2017 at 1:46 PM interviewed R#15 at her bedside. Queried R#15 if staff performed range of motion (ROM) on any of her limbs, and resident stated that no one does ROM, nor does anyone look at her toes. Visualized resident's toes and bilateral toes appeared to point downwards. On 08/17/2017 at 2:10 PM, the MRR on R#15 did not find any documentation on her toes being contracted. Queried Staff#162 about R#15's toe contractures and whether an assessment was done. Staff# 162 could not recall whether R#15 had toe contractures so went to assess the resident's toes. Accompanied Staff#162 to the resident's bedside and when she looked at resident's toes stated, "Oh yes, your toes are contracted."	4 173	3. We will review and revise current policies and procedures with guidance from a wound care specialist educator to ensure that we provide proper care for wound prevention and treatment based on the most current standard practices. We will hold weekly meetings with the PIP team. Also a "Weekly Wound Ulcer Reporting" form will be developed and used to promote communication between team members involved in the residents care. 4. The DON and QA will ensure that the continuous quality monitoring program is implemented effectively, and will report to the QA Committee for discussion and recommendations. R#15 The DON, wound care nurse (WCN), SRN, HN, and rehab department will implement corrective actions to ensure that comprehensive assessments are conducted and that all physical functioning and structural problems are addressed. 1. Res#15 was referred to the rehab department for PT screen (completed) and a CP for ROM was initiated to address the concerns. Nursing staff was provided ROM inservice by Rehab for this resident. Care plan for ROM was reviewed and updated by Rehab.	10/17/17 and ongoing 10/17/17 and ongoing 8/22/17

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4 173	Continued From page 33 Staff#162 stated that the CNAs usually do ROM and would have kept charge nurses informed. R#15 stated that no one does ROM and Staff#162 reassured the resident that she will let Rehab maintenance know to do ROM. At the nursing station requested to see any documentation that staff were aware of R#15's toe contractures. Staff#162 was unable to find anything in the resident's medical records, and stated that maybe in old RNA folder but no longer have RNA program and CNAs now do task. Staff#162 called Rehab staff and found out that R#15 was never on RNA program list and that Rehab would have to evaluate the resident. On 08/21/2017 at 9:41 AM reviewed R#15's EMR and the annual MDS 3.0 completed on 06/15/17 documented that the resident had impairment on both sides of upper extremities and lower extremities (hip, knee, ankle, foot) for functional limitation in ROM. The facility did not conduct comprehensive assessments to address all care needed by the residents to ensure proper foot care for R#106 with diabetes and peripheral vascular disease; and, R#15 ROM for bilateral toe contractures.	4 173	2. CNAs will now observe and report any skin conditions or contractures to the LNs on a daily basis through the Stop and Watch communication tool. LNs will be assigned to become "Skin Care Champions" for each unit. They will be trained to provide consistent assessments, properly characterize wounds, promote proper skin care procedures, and improve care and prevention of skin breakdown and wound management. Each Skin Care Champion will serve as the resource/educator for their unit. Rehab department will screen/assess for ROM on all new admissions/re-admissions. 3. We will review and revise current policies and procedures with guidance from a wound care specialist educator to ensure that we provide proper care for wound prevention and treatment based on the most current standard practices. We will hold weekly meetings with the PIP team. Also a "Weekly Wound Ulcer Reporting" form will be developed and used to promote communication between team members involved in the resident' care. 4. Random checks by the DON, SRN, HN and/ or QA and Medical Director to assess overall skin conditions or extremities for example. These outcomes will be reported to the QAPI committee for further discussion and recommendations.	9/05/17 10/17/17 and ongoing 10/17/17 and ongoing
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education.	4 174		

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4 174	Continued From page 34 This Statute is not met as evidenced by: Based on closed record review and staff interviews, the facility failed to develop and implement a comprehensive, person-centered care plan that includes measurable objectives and timeframe to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 32 residents (Res #128). Finding includes: Cross-reference to findings at F314. Res #128 was admitted to the facility on 4/27/17 for skilled nursing services with diagnoses that included sepsis, fever, sacral decubitus Stage 3, chronic kidney disease stage 3, hypertension, dementia and constipation. The record review found a handwritten entry by Staff #59 dated 4/27/17 for "Stage 3 open area to coccyx." This was added to an existing at risk for skin breakdown care plan dated 5/5/17. However, the approaches to this care plan included range of motion exercises and device applications to prevent further contractures to the fingers, hand and elbow. It also included an intervention for nursing "to place disposable washcloths to scrotal area & cover with blue brief (to minimize irritation from urine touching skin)." Res #128 is a female. There were no approaches to comprehensively address the resident's problem of a Stage 3 open pressure ulcer within this care plan as there were no measurable goals/timeframe, appropriate treatment interventions and/or approaches to heal the wound. On 08/21/2017 at 1:30 PM, during a concurrent record review with the DON, she verified the existing care plan was not related to the Stage 3	4 174	Res#128 1. Res#128's chart is a closed chart. Discussed and re-educated the HNs and LNs who cared for this resident that the care plan did not accurately reflect the resident's specific needs. They acknowledged and understood the need for an individualized care plan The care plan will include measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs. 2. Residents with wound and other conditions will be identified and reported weekly to the DON and Medical Director. The IDT will routinely review their care plans to ensure that the care plans have measurable goals/time frames, appropriate treatment interventions and/or approaches to heal the wound. 3. The DON in-serviced the SRNs, HNs, and IDT on developing person centered care plans to meet the medical, nursing and psychosocial needs of the resident. The RAI will submit the list of residents with wound care plans that were completed to the DON and Medical Director. 4. DON and QA will do monthly care plan review for all residents with wounds. Findings will be reported at QAPI committee for further recommendations. Medical Director will do spot checks.	822/17 8/22/17 8/22/17 and ongoing 8/22/17 and ongoin

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4 174	Continued From page 35 coccyx wound. The DON said, "This doesn't even pertain to the resident." The DON also stated the wound also had to be measured because, "it will tell us if it's healed. It's not healed with no measurements." The facility failed to develop an accurate comprehensive care plan for a resident identified to be at risk for skin breakdown and was admitted with a Stage 3 pressure ulcer to the coccyx.	4 174		x
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure the residents' existing comprehensive care plans were evaluated and revised as the resident's status changed for 4 of 32 residents (Residents #12, #71, 38, #114) in the Stage 2 sample. Findings include: 1) Cross-reference to findings at F226. During a concurrent record review and interview with Staff #59 on 08/16/2017 at 2:40 PM, it was found Res #12's care plan #9 for problem related to history of conflict with resident was not updated to include Res #71. This was confirmed by Staff #59 who stated she did not update it. She said	4 175	Res#12 1. Care Plan #9 was reviewed and updated to address conflict related to Res#71 to promote a safe environment for residents and for this resident's well-being. 2. During weekly care conferences, the IDT will review care plans and revise as needed to reflect resident's needs and problems. 3. Care plan conference process modified to focus on reviewing and revising individualized care plans to patient-centered care plans in order to meet their needs and preferences. 4. Random checks by the DON, SRN, HN and/or QA and Medical Director to assess overall skin conditions or extremities for example. These outcomes will be reported to the QAPI committee for further discussion and recommendations.	8/22/17 8/22/17 8/22/17 10/17/17 and ongoing

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4 175	Continued From page 36 the existing care plan stating, "All staff to ensure res is not seated next to/near res (27607/BL) at any time" referred to a resident who had been discharged. Staff #59 said the current plan of care thus had not been updated to include Res #71's targeting obsession to take Res #12's baseball cap, which was not his property. Staff #59 said, "I haven't done it yet. Although not written here, the staff know should not be sitting together" but acknowledged it was to have been put into a care plan. 2) For Res #71, his attending physician's note of 3/1/17 identified the resident with, "New hyper sexual behaviors and comments noted by staff." The physician's note did not elaborate what the new hyper sexual behaviors/comments were and to trial Paxil. A care plan for "Socially inappropriate behavior" developed on 3/2/17 included the Paxil use, and "All staff to closely observe resident for inappropriate behavior like: touching/grabbing staff's buttocks/take appropriate steps such as redir provide an alternate activity." The 5/5/17 Interdisciplinary Conference Notes stated, "Resident has been observed w/worsening of inappropriate behavior like grabbing/touching staff buttocks and refusing to take his medications ..." Yet, based on the observation of the res-to-res incident on 8/14/17 by surveyors, and other random observations of Res #71 on the unit, during an interview with the DON on 8/15/17, the DON stated the care plan was incorrect. The DON said it should have been for "sexually inappropriate and not socially inappropriate" behaviors for Res #71. The approach for a referral to a geropsych consult with managing the resident's behavior also had no date as to when this addition to the care plan was made.	4 175	1. R #71 was observed to deliberately snatch the baseball cap off R#12' head while sitting at their table. The following measures were immediately implemented for the safety of the residents involved, as well as other residents: • Ensured that dining room services are supervised at all times. • Immediately initiated an Event Report to document the altercation between the two residents. Completed the required reports for State agencies including the Office of Health Care Assurance (OHCA) and Adult Protective Services (APS). • Reviewed and revised the care plan (CP) for R #71 to provide room changes as appropriate, plan to address current behaviors with the psychiatrist' input, and develop specific structured plans for periods when the resident is out of bed, e.g., plans for recreational activities and meal times. Also for the safety of others, a plan to discharge or transition the resident to a less stimulating environment will be developed for his own well-being and as needed to protect other residents and staff (as recommended by his Geri psychiatrist). The family' input was also considered to revise the care plan.	8/22/17

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4 175	Continued From page 37 3) Cross-reference to F309. On 08/15/2017 at 2:39 PM, Res #38 was observed in bed with her lower legs uncovered. It was found her right lower shin area had a dressing applied to it and her left shin area had a large bruised area to it. The resident is non-interviewable. On 08/17/2017 at 12:53 PM, record review found Res #38 was readmitted to the facility on 4/18/17 after a hospital stay post-fall. Her initial skilled nursing admission record however, found when she was admitted on 7/25/13, there was documentation of "BLE (bilateral lower extremities) with small faded bruises." Both staff were further queried if a readmission baseline skin assessment was not done, how would staff determine whether Res #38's skin condition was improving or worsening, and what changes were actually being monitored for. Staff #72 said as nurses they see the resident every day so they can tell if it's an old discoloration versus a new bruise. When surveyor further queried if monitoring is being done, when did her bilateral lower extremity skin condition change from being small faded bruises to a larger discoloration. Surveyor finally asked Staff #59, "Where's your baseline measurement for this discoloration? There is none?" Staff #59 nodded affirmatively that there was none. As such, the resident's existing care plan #5 for at risk for skin breakdown was never reviewed nor revised with changes to the resident's bilateral lower extremities. The DON also verified this on 8/21/17. 4) Cross Reference to F315. Resident #87 exhibited a decline in urinary continence from admission to the 90 day evaluation. On admission, the resident was coded as being occasionally incontinent (less	4 175	2. During weekly care conferences, the IDT will review care plans and revise as needed to reflect resident's needs and problems. 3. Care plan conference process modified to focus on reviewing and revising individualized care plans to patient-centered care plans in order to meet their needs and preferences. 4. DON, SRN, and QA will conduct random checks during care conference meetings. DON/QA will report findings to QAPI committee for oversight to ensure compliance. R#38 1. Care Plan was reviewed and updated to reflect current skin conditions i.e, measurements and a goal to prevent complications such as skin break down and skin infections. Also a Doppler test was completed to determine the etiology and the attending physician documented his evaluation of the current skin condition. 2. During weekly care conferences, the IDT will review care plans and revise as needed to reflect resident's needs and problems. 3. Care plan conference process modified to focus on reviewing and revising individualized care plans to patient-centered care plans in order to meet their needs and preferences. 4. DON, SRN, and QA will conduct random checks during care conference meetings. DON/QA will report findings to QAPI committee for oversight to ensure compliance.	8/22/17 8/22/17 10/17/17 8/22/17 8/22/17 8/2217 10/17/17

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4 175	Continued From page 38 than seven episodes of incontinence) and at 90 days was coded to as frequently incontinent (seven or more episodes of urinary incontinence, but at least one episode of continent voiding). An interview with Staff Member #110 confirmed the interdisciplinary team did not assess for causal factors contributing to the decline in bladder continence. Based on an assessment of the causal factors contributing to the decline, the facility did not revise Resident #87's care plan to implement interventions to maintain or improve the resident's bladder functioning. 5) Cross reference to F323 On 08/16/2017 at 3:30 PM met Staff#116 and showed her R#114's care plan (CP) which had written interventions "Seat belt alarm when in W/C, Bed alarm when in bed and Bilateral fall mats." Staff#116 stated that the interventions were written by her and recognized the hand writing as her own. The staff member could not remember when she wrote it in R#114's CP as there was no start date for these interventions on the CP. Staff#116 also stated that the facility used a CP template and the intervention, "Staff to follow procedures as specified in Leahi policy for Physical restraints #110-3-14," with a start date of 09-12-16, was not removed although R#114 was never put into restraints.	4 175	The DON, SRN, HN, RAI and IDT will implement corrective action for residents R#15, R#106 affected by this practice including: 1. Res#15 - Contracted toes were referred to Rehabilitation department and recommended passive ROM to contracted toes. LN and CNAs were inserviced on proper ROM procedure. Care Plan was developed. 2. Residents with existing contractures were Care Planned to ensure these contractures will not deteriorate. 3. The Stop and Watch communication tool was implemented for prompt reporting and referral if needed to ensure care plans are developed to meet the residents needs, i.e.,daily skin condition reporting by the CNAs or caregivers. - Staff was inserviced on identification of contractures and need for referral either to a podiatrist and/or Rehab department or any services required to meet their needs. For new admissions/rehab admissions, the Rehab department will screen for and develop plans to manage contractures. 4. Random checks by the DON, SRN, HN and/or QA and Medical Director to assess overall skin conditions or extremities for example. These outcomes will be reported to the QAPI committee for further discussion and recommendations.	8/22/17 8/22/17 and ongoing 8/22/17 and ongoing 10/17/17 and ongoing
4 177	11-94.1-44(a) Specialized rehabilitation services (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	4 177		

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4 177	Continued From page 39 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 observations, medical record reviews (MRR) and interviews, the facility failed to ensure that 1 of 41 residents (R#15), received appropriate treatment and services to prevent further decrease in range of motion (ROM). Findings include: On 08/14/2017 at 12:26 PM, while interviewing R#15 noticed that her bilateral toes looked contracted. On 08/17/2017 at 1:46 PM interviewed R#15 who was lying in bed covered with a sheet. Queried resident if staff performed ROM exercises on any of her limbs. The resident stated that no one does ROM and also stated that toes have been contracted for awhile now and that staff never look at her toes. The R#15 allowed surveyor to visualize her toes and bilateral toes appeared contracted downwards. On 08/17/2017 at 2:10 PM, R#15's MRR found no documentation of bilateral toes contractures. Queried Staff#162 and she went to look at R#15's	4 177	The DON, SRN, HN, RAI and IDT will implement corrective action for residents R#15, R#106 affected by this practice including: Res#15 1. Contracted toes were referred to Rehabilitation department and recommended passive ROM to contracted toes. LN and CNAs were inserviced on proper ROM procedure. Care Plan developed. 2. Residents with existing contractures were Care Planned to ensure these contractures will not deteriorate.	8/22/17 8/22/17 and ongoing 8/22/17 and ongoing

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4 177	Continued From page 40 toes. While looking at the resident's toes, Staff#162 stated, "Oh yes, your toes are contracted." Queried when nursing assessments would have noticed contracted toes and Staff#162 stated, CNAs usually do ROM and should have kept charge nurses informed. The resident stated that no one does ROM on her, and Staff#162 reassured R#15 that Rehab maintenance will do ROM. At the nursing station and asked Staff#162 for documentation on assessments of R#15's toe contractures. The Staff#162 was unable to find any documentation regarding toe contractures in R#15's MR's. Staff# 162 stated facility no longer have restorative nursing assistant (RNA), and that CNAs now do ROM task. Staff#162 called Rehab department to check if R#15 used to be on the RNA maintenance program, but Rehab Staff#80 told her that R#15 was never on Rehab maintenance program list. Staff#162 then stated that someone from Rehab would come to evaluate R#15 for maintenance program. The MRR on R#15 found that the resident was alert and oriented as documented on the annual interdisciplinary (IDT) conference notes dated dated 6/22/17. The Wound Care Measurement and Assessment form dated 8/14/16 and completed by Staff #156, of the resident's left (L) great toe open lesion, included a color picture of the wound on the contracted big toe. The Wound Care Measurement and Assessment form dated 7/28/16 and completed by Staff#162, of skin tears on the resident's R 1st & 2nd toes, included a picture of the wounds and toes contracted. On 08/17/2017 at 3:29 PM interviewed Staff#71 and he was shown pictures as described above. Staff#71 stated that the L great toe looked arthritic. Queried whether staff will not do ROM	4 177	3. The Stop and Watch communication tool was implemented for prompt reporting and referral if needed to ensure care plans are developed to meet the residents needs, i.e.,daily skin condition reporting by the CNAs or caregivers. Staff was inserviced on identification of contractures and need for referral either to a podiatrist and/or Rehab department or any services required to meet their needs. For new admissions / readmissions, the Rehab department will screen for and develop plans to manage contractures. 4. Random checks by the DON, SRN, HN and/or QA, and Medical Director to assess overall skin conditions or extremities for example. These outcomes will be reported to the QAPI committee for further discussion and recommendations.	8/22/17 and ongoing 10/17/17 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	08/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

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4 177	Continued From page 41 for contracted toes if arthritic, and Staff#71 replied that Rehab makes recommendations for ROM. Informed Staff#71 that Rehab didn't know about R#15's toe contractures as Staff#162 checked with them. Staff#71 reiterated that Rehab recommends ROM and responsible for evaluating contractures. Queried Staff#71 whether there were P&P's or process that staff followed to let Rehab know what residents needed to be evaluated for contractures; and/or whether nursing staff should have reported after doing skin assessments on contracted toes. Staff#71 stated that the facility doesn't have P&P's and should be standard nursing practice. Went to discuss R#15's MRR with Staff#70, and she stated that the facility does have a process to let Rehab know about contractures for evaluation. On 08/21/2017 at 9:41 AM reviewed R#15's EMR and the annual MDS 3.0 completed on 06/15/17 documented that the resident had impairment on both sides of upper extremities and lower extremities (hip, knee, ankle, foot) for functional limitation in ROM. The resident was admitted with limited range of motion and did not receive appropriate treatment and services to prevent further decrease in range of motion.	4 177		