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
	125065	A. BUILDING: _____ B. WING RECEIVED	09/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HILO REHABILITATION & NURSING C	563 KAUMANA DRIVE 2017 OCT 27 A 10:26 HILO, HI 96720

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4 000	11-94.1 Initial Comments A relicensure survey was conducted by the Hawaii State Survey Agency from September 18 to 22, 2017. At the time of entrance, the facility census was 79 residents. The facility is licensed for 82 beds.	4 000		
4 112	11-94.1-27(1) 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: (1) The free exercise of rights as a resident of the facility and as a citizen or resident of the United States; This Statute is not met as evidenced by: Based on observation and family and staff interviews, the facility failed to maintain resident's right for 3 of 23 residents/ families interviewed to choose their daily schedule. (Resident #79, #20, #68). Findings include: 1) Resident #79 was observed on 9/19/17 at 8:00 AM at the Kona Nurses station in her wheelchair sleeping. During a family interview on 9/19/17 at 9:04 AM a family member reported that Resident #79 schedule varies, sometimes she wants to sleep	4 112	**4 112 Residents Rights and Facility Practices** For res # 79; resident family was interviewed by Social Services on 9/29/17 regarding preference regarding time to be awakened in the morning and if resident also had any preference regarding time to go to bed. Resident family member indicated that the resident preferred to be awakened at approximately 9:30 a.m. and wanted to go to bed in the evenings at approximately 8 p.m. Care plan was revised to indicate resident preference with notification to all staff regarding resident's verbalized preferences. Interview of all other residents that had previously indicated a preference/choice of awaking and/or going to bed and all new residents was conducted by Social Services designees. A listing of all residents that verbalized specific preferences was developed indicating preference(s) schedule and forwarded to CNA Captain, RCMs, MDS Coordinator and DON. Review of resident care plans was conducted and revised as appropriate to reflect resident wishes. Huddles were held with all staff regarding honoring and acknowledging resident preferences and choices, need to review care plan and validate with resident to assure that resident wishes to continue adhering to the indicated preference. To prevent deficient practice from recurring, Social Services will revise their assessment form to include preference relating to times of waking in the morning and going to bed in the evening, and updating their spreadsheet ongoing. Ongoing communication will occur with MDS Coordinator, CNA Captain , RCM and DON to ensure information is incorporated into care plans and CNA(s) orientation/training and schedule will acknowledge and accommodate resident preferences. Weekly audits will be conducted by CNA Captain to assure compliance and quarterly interviews and satisfaction surveys will be conducted by Social Services. Staff in-service provided regarding Plan of Correction and changes in process developed to address deficient practices as identified in survey of 9/18-22/2017. Ongoing monitoring and evaluation will be conducted by CNA Captain, Social Services and DON and presented and addressed at QAPI meetings to ensure compliance.	9/29/17 9/29/17 and Ongoing 9/23/17 and Ongoing 9/29/17 and Ongoing 9/23/17 Ongoing

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/26/17

10/27/17 2

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4 112	Continued From page 1 longer in the morning. She is irritable when staff wake her up too early in the morning. An interview with Staff # 13 at 1:30 PM revealed that while the CNA assigned to showers usually get the residents up between 5:30 AM and 6:30 AM on shower days, a resident may ask to sleep later. Preferences on what time to wake up in the morning is not asked during the resident assessment interview. If a family member wishes for the resident to wake up later in the morning they can make the request to the nursing staff. An interview with staff #116 stated the CNAs usually get the residents up between 5:30 AM and 7:30 AM for morning care and breakfast. If a Resident tells the CNA they don't want to get up for morning care at that time they can get up later. Resident #79 was observed on 9/21/17 at 8:15 AM sitting up in wheelchair at the Kona nurses station sleeping. The facility failed to allow Resident #79 to choose when to wake up in the morning. 2) On 9/19/17 at 8:47 A.M. Resident #20 reported he was not notified of a room change prior to the change. The resident reported he was moved four times and was not notified. A review of Resident #20's record documents, on 8/12/16 he was admitted to Room 167-B. Subsequently, Resident #20 was moved three times, including: 8/15/16 to Room 167-A; 1/30/17 to Room 116-A; and on 7/27/17 to Room 139-B. On 9/18/17 at 2:22 P.M., Resident #68 reported he/she was not notified of a room change prior to the move. A record review found Resident #68	4 112	Continued from page 1 4 112 Residents Rights and Facility Practices Legacy Hilo Rehabilitation and Nursing Center is committed to ensure that timely documentation will be conducted when residents are transferred/discharged within and from the facility. On 9/25/17 a review of room transfers was conducted by Social Services designees. It was identified that since July 2017, 3 residents had room changes, which were all documented in EMR, after an additional staff was added to the Social Services department. Social Services designees were retrained on the importance of documenting all resident transfer/discharges, including room changes with completion of applicable notification to resident and/or resident representative and appropriate agencies including but not limited to LTC Ombudsman and Hawaii Disabilities Rights agency. To prevent recurrence of this deficient practice chart audits will be conducted for all resident including room changes to ensure appropriate documentation is completed by Medical Records, Health Information Manager. Review of resident discharge/transfer policy and procedure was conducted with Social Services designees to ensure that process is clear and will be implemented as required. Staff in-service provided regarding Plan of Correction and changes in process developed to address deficient practices as identified in survey of 9/18-22/2017. Ongoing monitoring and evaluation will be conducted by Social Services Department, Licensed Social Worker and Medical Records Health Information Manager and presented and addressed during QAPI meetings to ensure compliance.	9/25/17 9/23/17 9/25/17 9/25/17 9/23/17 Ongoing

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4 112	Continued From page 2 was admitted on 6/17/16 to Room 142-B. The resident was moved on the following dates: 7/28/16 (Room 140-A); 7/31/17 (112-A); and 8/8/17 (Room 114-B). An interview was conducted with Staff Member #9 on 9/21/17 at 3:50 P.M. Inquired whether social services notifies residents of a room change and if this is documented in the residents' record. The staff member replied, social services does not document in the progress notes to notify a resident of a room change. The staff member reported social services are responsible to visit with the resident one to two days later to inquire how they are getting along with their new roommate. The staff member further reported room changes are not documented as there are so many room changes. A concurrent record review was done with the staff member, the staff member confirmed the aforementioned room changes for Residents #20 and #68. A request was made to review the facility's policy and procedures related to room changes. The staff member provided the social services policy and procedures binder and later was asked to locate the policy regarding room changes. A review of the policy entitled Room Change (SSA2.16) notes the procedure for social services includes the following: "3. Makes a room change decision based on the resident's best interest; 4. Notifies the resident, responsible party, previous roommate and new roommate; 5. Documents the evaluation, decision and notification in the medical records; and 7. Monitors the resident's acclimation to the new environment 72 hours after the move and then periodically, documenting monitoring and interventions..." On the morning of 9/22/17, Staff Member #83 reported the facility has a form that is used to	4 112	4 112 Residents Rights and Facility Practices See page 1-2	

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4 112	Continued From page 3 document room changes. A request was made to review the documents for Residents #20 and #6. Prior to the completion of the survey on 9/22/17 and exit of the survey team, documentation was not provided. The facility failed to ensure residents with room changes or roommate changes are notified in writing of the change and the reason for the changes. The facility was also unable to produce documentation to verify notification was provided to the residents.	4 112	4 112 Residents Rights and Facility Practices See page 1-2	
4 127	11-94.1-28(a) Resident accounts (a) In the event the resident or family member requests the facility to manage the resident's personal funds, an itemized account shall be made available in writing to the resident or the legal guardian or surrogate, and shall be maintained and kept current for the resident, including: (1) Written receipts for all personal possessions and funds received by or deposited with the facility; and (2) Written receipts for all disbursements made to, or on behalf of, the resident. This Statute is not met as evidenced by: Based on an interview with staff members, the facility failed to ensure conveyance upon death of a resident's funds within 30 days for 2 (Residents #135 and #30) of 3 residents sampled. Findings include:	4 127	4 127 Residents Accounts Legacy Hilo Rehabilitation and Nursing Center is committed to ensure that conveyance of resident trust fund balances are completed within 30 days of discharge or death of resident. A review of the process of disbursement of trust fund monies for upon the death of the residents was conducted. Business Office will ensure that residents will be distributed balance of all trust fund monies within 30 days of discharge or death of resident, unless extenuating circumstances occur which would delay the conveyance of such monies. When a delay is anticipated, the facility shall provide notification to the resident and/or resident representative of the delay and will provide an approximate time frame by which monies will be disbursed. Residents will also be informed of the process at the time of admission, which will also be included in the resident handbook. Al residents were informed/notified of process and provided the opportunity to make necessary changes as applicable via the Resident Trust Fund Authorization form to ensure that their wishes are honored. Revision to resident handbook completed to address process and ensure that all residents are aware of the facility process at the time of admission. Policy to address trust fund conveyance to residents at time of discharge or death has been developed. Business Office staff was provided training on the requirements of Trust Funds and timely disbursement, and review/revision of Resident Trust Fund Authorization form completed. Staff in-service provided regarding Plan of Correction and changes in process developed to address deficient practices as identified in survey of 9/18-22/2017. Ongoing monitoring and evaluation to be conducted by Business Office Manager and Administrator and presented and addressed at QAPI meetings to ensure compliance.	9/22/17 thru 9/28/17 10/9/17 thru 10/10/17 10/13/17 1/13/17 10/13/17 9/23/17 Ongoing

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4 127	Continued From page 4 On 9/21/17 at 10:30 A.M. an interview was conducted with Staff Member #A and the facility's consultant. The staff member and consultant provided a listing of residents who expired in the last 3 to 6 months. Resident #135 was reported to expire on 5/18/17, the remainder of the resident's funds were paid in cash to a family member on 9/14/17. The consultant reported the facility is currently working on settling the accounts of the residents who have expired. On 9/21/17 at 11:51 A.M. a review was done for Resident #75. Resident #75 expired on 8/26/17, the account has been closed with the resident owing the facility money. Another review was done for Resident #30. Resident #30 expired on 8/15/17, the resident's account remains open with $40.00 remaining in the account; however, the resident still owes the facility money. The facility failed to ensure the system for conveyance of expired residents' personal funds accounts are balanced and any funds remaining in their accounts are given to their family member/representative.	4 127	4 127 Residents Accounts See Page 4	
4 128	11-94.1-28(b) Resident accounts (b) Upon request of each resident or legal guardian or surrogate, articles kept for safekeeping shall be released. This Statute is not met as evidenced by: Based on interviews with resident and staff member, the facility failed to ensure a resident's funds are managed to allow residents access to their personal funds when needed.	4 128	4 128 Resident Accounts Notice to all residents with trust funds was sent regarding the availability of funds during weekends and evenings of no more than $20, unless advance notice is provided, shall be available at the reception desk up to from 4 p.m. to 7 p.m. week days and 8 a.m. to 7 p.m. on weekends (7 days/week). Residents wishing to receive amounts greater than $20 are recommended to make arrangements with the Business office by the Friday prior to the weekend or by 12 noon of the respective evening, so that funds can be made available as needed. Revision to resident handbook completed to address new process and ensure that all residents are aware of facility process at the time of admission. Policy to address availability of trust fund monies has been developed and training of all Business staff was conducted.	10/13/17 10/13/17 10/13/17

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4 128	Continued From page 5 Findings include: On 9/18/17 at 11:51 P.M. Resident #122 reported he has a personal funds account with the facility. The resident reported that he is unable to get money on the weekend, he is only able to access his funds Monday through Friday. On 9/21/17 at 10:30 A.M. an interview was done with Staff Member #A and the facility's consultant. The staff member and consultant confirmed Resident #122 has a personal funds account with the facility. Inquired whether residents are able to access their personal funds account on the weekend. Staff Member #A replied, perhaps the resident will have to wait until Monday to get their money when the business office is open which is Monday through Friday from 7:30 A.M. to 4:30 P.M. The facility failed to develop a system to ensure residents have the right to access their personal funds account at any time.	4 128	Continue from page 5 4 128 Resident Accounts Management staff informed about change in process for availability of resident personal during weekends and to hold huddles with staff to ensure staff knowledge of change. Staff in-service provided regarding Plan of Correction and changes in process developed to address deficient practices as identified in survey of 9/18-22/2017. Ongoing monitoring and evaluation to be conducted by Business Office Manager and Administrator and presented and addressed during QAPI meetings.	9/29/17 9/23/17 Ongoing
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and	4 136	4 136 Resident Care Legacy Hilo Rehabilitation and Nursing Center is committed to ensure that residents are assessed ongoing to prevent skin breakdown and/or pressure injuries/wounds. Resident # 19 chart was reviewed on 9/22/2017 and it was identified that resident was admitted 5/1/17 with multiple Dx: Sepsis, Unspecified organism, Acute Kidney Failure, HTN, Anemia, Other primary thrombocytopenia, Hypo-osmolality and hyponatremia, Cerebral Aneurysm, Other Sequelae of cerebral infarction, [redacted] Cognitive communication Deficit, Unspecified-Calorie Malnutrition, Cachexia, Pressure Injury Left Hip Stage 4, Major Depressive Disorder, Single Episode. Weight upon admission was 99lbs. Labs conducted on 5/8/17 and 5/11/17 identified early stages of kidney failure. [redacted]	9/22/17

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4 136	Continued From page 6 (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to attain or maintain the highest practicable physical and psychosocial well being for two residents, Resident #19 and Resident #166. Findings include: 1) Resident #19 was admitted to the facility from an acute care facility with diagnoses which included adult neglect with Adult Protective Services (APS) involvement; Stage IV pressure injury to left hip with visible tendon; osteomyelitis; and malnutrition. A review of Resident #19's history noted he was admitted to the long term care (LTC) facility from an acute care facility (1/24/17-5/1/17). The history further noted he was admitted to the acute care facility in septic shock due to multiple stage 4 pressure injuries with osteomyelitis. The wounds were infected with bacteria and contained maggots. During his acute care stay, Resident #19's [redacted] Resident #19's acute care stay was further complicated with antibiotic resistant bacterial infections which required management by an Infectious Disease Specialist. Resident #19 was finally discharged from the acute care facility on 5/1/17 when he was admitted to the LTC facility. Resident #19 was being reviewed for hospice services during stage 2 of the QIS survey.	4 136	Continued from page 6 Resident was admitted with an active [redacted] infection to left hip and was placed on antibiotics for 7 days. Wound care to left hip wound lead to progressively improved condition as demonstrated by: measurement 5/1/17 5.0cm x 6.0cm x 1.0cm; gradually went down to 3.0cm x 2.0cm x 1.0cm 6/5/17; 3.0 cm x 2.0cm x 1.0cm 6/13/17; however a slight change of 3.5cm x 2.0cm x 1.0cm 6/19/17 which is a direct correlation of active infection; 3.3cm x 2.0cm x 0.8cm on 7/6/17; and 2.0cm x 1.5cm x 0.4cm on 7/12/17 with wound care ongoing to date. As of 10/6/2017 wound measurements were 0.6 cm x 0.4cm x 0.2cm. Weekly skin checks were performed since admission. On 6/8/17 Stage 2 PI. 1.0cm x 1.0cm x 0.1 on right hip area injury was documented; with skin check of 6/5/17 identified "skin intact". It is speculated that the Stage 2 injury could have been related to an underlying infection as a systemic infection was identified on 6/11/17. Resident received 3 courses of different antibiotics and the wound resolved on 6/25/17. During this course, resident's average temperatures ranged from 100° to 101°F with average food consumption ranging from 0% to 75% for approximately 7 days; then increased to 25%-100% towards the end of the infection phase. During this period, resident exhibited signs of system deterioration with signs of actively dying, should he not have recovered from the systemic infection. 6/19/17 Right Hip PI 3.0cm x 2.0cm x 0.1 - Direct Correlation to active infection; 6/26/17 Right Hip PI 3.5cm x 2.0cm x 0.1 – gradual deterioration, suspected active dying phase; 7/6/17 Right Hip Unstageable 3.5cm x 2.0cm x 0.1 100% yellow slough; 7/12/17 Right Hip Unstageable 2.5c x 2.0cm x 0.1 100% yellow slough; 7/20/17 Right Hip Unstageable classified as stage 4 PI 2.0 cm x 1.5 cm x 0.4 cm with wound care ongoing. As of 10/6/2017 wound measurements were 0.4 cm x 0.5 cm x 0.1 cm with 100% granulation. On 5/8/17, resident was started on Juven po bid, Vitamin C po qd, and Multivitamin 1 tab po qd; on 5/25/17 Nepro 240ml po bid was started, with nutritionally Enhanced Meals started on 7/12/17. If resident was able to consistently eat 100% of meals, the combined total protein of meals and supplements provided 124.5 grams of protein a day. According to the RD, resident required 60 grams of protein/day to promote wound healing. However, resident continued to lose weight as identified by weights taken 7/3/17 82.9 lbs and 8/1/17 69.2 lbs. Therefore, it was suspected that the resident had an underlying metabolic/absorption problem which prevented consistent wound healing and the development of pressure injuries despite consistent care provision. During the phases of active infection resident's wounds increased in severity and did not respond positively to treatment; however status post active infection, wound improvement was evident.	9/22/17

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4 136	Continued From page 7 Resident #19 was admitted to hospice services on 5/12/17. During the hospice investigation, Surveyor identified concerns related to Resident #19 developing a pressure injury after admission to the LTC facility. Observation of Resident #19 on the afternoon of 9/20/17 found him lying in bed watching TV. He was nonverbal and unresponsive to questions. He made eye contact. Observation of Resident #19 on the morning of 9/21/17 found him lying in bed watching TV. Resident #19 was unresponsive but made eye contact. During the morning of 9/21/17, an observation of dressing change for Resident #19 found he had a healing stage IV pressure injury on his left hip. The stage IV pressure injury on Resident #19's left hip appeared to have significantly improved and was noted to be clean, dry and the tissue appeared healthy. During the dressing change, it was observed that Resident #19 also had a pressure injury on his right hip along with 2 additional pressure injuries on his right foot. The Wound Nurse noted Resident #19 developed a pressure injury on his right hip and two pressure injuries to his right foot after being admitted to the LTC facility. The Wound Nurse further noted the pressure injury on Resident #19's right hip was a stage IV. On the morning of 9/21/17 at approximately 10:30 A.M. a medical record review found Resident #19 developed the pressure injury on his right hip on 6/8/17. The initial pressure injury assessment dated 6/8/17 noted the right hip wound was a stage II and measured 1.0 cm length x 1.0 cm width x 0.1 cm depth. The plan noted: Initial assessment of pressure injury; Hospice notified for air mattress order; New treatment in place. A review of the Weekly Pressure Injury	4 136	Continued from page 7 Review of other residents with wounds was conducted on 9/25/2017. Wound care/hearing regimen, treatment modalities, status were reviewed to ensure timely application of care, documentation completed, care plans updated as appropriate and positive outcomes are being achieved. On 9/23/17 huddles were conducted with all staff to review the importance of conducting ongoing skin care, assessments and documentation of observations/assessments/findings with appropriate reporting to LN and IP/Skin Care Coordinator for follow-up and evaluation. 9/25/17 review of skin care policy and procedure was reviewed. Revision made to ensure that for residents assessed to be at high risk for skin breakdown be considered for repositioning more frequently than every 2 hours and documentation be consistently completed. To prevent deficient practice from recurring, the following has been implemented: 1. Consideration of more frequent turning for residents at high risk for skin breakdown 2. Consideration of ordering air mattress at time of admission for residents presenting with wounds and/or immediately as the need is identified 3. Ongoing communication and collaboration with Hospice and/or other agencies involved in the care of the resident to ensure the provision of assistive devices as requested/determined to be beneficial 4. Ongoing communication with resident and/or resident representative to discuss status and options for care available. 5. Weekly audits to be conducted by CNA Captain of all direct care staff to ensure proper skin care is being provided and with timely repositioning as indicated on the care plan 6. Monthly audits will be conducted of all LNs during provision of skin and wound care with timely and complete documentation by IP and Staff Development RN to determine competency 7. All residents admitted under Hospice care/services with wounds will be placed on air mattresses immediately. On 9/29/2017 during scheduled Infection Control training, Pressure injury, review of survey citations and immediate implementation of corrective measures completed. Staff in-service provided regarding Plan of Correction and changes in process developed to address deficient practices as identified in survey of 9/18-22/2017. Ongoing monitoring and evaluation to be conducted by CNA Captain, IP/Skin Care Coordinator and DON with presentation and review during QAPI meetings to ensure compliance.	9/25/17 9/23/17 9/25/17 9/25/17 and Ongoing 9/29/17 9/23/17 9/25/17 and Ongoing

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4 136	Continued From page 8 Assessments found one dated 7/6/17 where Resident #19's wound deteriorated to an unstageable pressure injury and the wound measurements increased: 3.5 cm length x 2.0 cm width x 0.1 depth. The plan noted, "Hospice nurse notified for possible treatment of Santyl ointment daily dressing changes." The Weekly Pressure Injury Assessment dated 8/11/17 noted Resident #19's pressure injury was a stage IV pressure injury (previously unstageable) and measured 3.0 cm length x 2.0 cm width x 0.8 cm depth. The plan noted, "Majority of slough not present this assessment. Able to see red granulated wound bed." Further review found Resident #19 developed two pressure injuries to his right foot on 6/30/17. The Wound Nurse assessed the wounds as "suspected deep tissue injury" without signs or symptoms of infection and measured 1.5 cm length x 1.5 cm width x 0 cm depth. The Plan stated, "2 deep tissue injuries located to lateral right foot both 1.5 cm length x 1.5 cm width, light brown in discoloration and skin intact". The Weekly Pressure Injury Assessment of the resident's right foot pressure injuries dated 7/12/17 noted the wounds deteriorated and measured 1.8 cm length x 3.0 cm width x 0 cm depth. Plan stated, "Continue floating right foot". Another Weekly Pressure Injury Assessment dated 8/18/17 noted the right foot pressure injuries had deteriorated and measured 1.0 cm length x 1.5 cm width x 0 cm depth. Plan stated, "Continue to offload pressure of right foot". Despite 75-100% meal intakes, Resident #19's last documented weight was on 8/9/17, 69 pounds. A review of the facility's "Skin Check Body Diagram" noted the following: 6/19/17 No new skin changes noted this shift. Wounds to bilateral hip dressing changed by Wound Nurse. Dressing	4 136	Continued from Page 8 Legacy Hilo Rehabilitation and Nursing Center is committed to ensure that all staff is aware of care plan interventions for residents with PCP orders for therapeutic diets. Legacy Hilo is also committed and recognizes the New Dining Practice Standards by the Pioneer Network 8/2011 rev 2013 and recognized by CMS For Res #166, a review of resident's assessment and care plan was conducted on 9/22/17. Resident has indicated preference of eating in his/her room. Staff were conducting periodic checks during resident meals to ensure safety. 9/23/17 huddles held with staff re: the need to ensure that residents with swallowing difficulties will be monitored during meals and snacks to ensure safety of resident and if any incidents of coughing, choking, etc., occur, staff to inform LN immediately and take appropriate measures to ensure resident safety. A review of all residents with similar conditions was conducted to identify in residents that prefer to eat in their rooms. It was determined that 22 residents choose to eat in their rooms. For those choosing to eat in their own rooms, 4 residents were identified to have swallowing difficulties, with staff providing frequent checks/observations/inquiries but not sitting and monitoring residents throughout the entire meal process. To prevent recurrence of the deficient practice, all residents assessed to have swallowing problems were interviewed regarding dining preference and discussed the need for close monitoring due to possible negative outcomes and the need for prompt response. For residents requesting to eat in his/her room, staff will be assigned to monitor resident during meals, which will be indicated on resident care plan. Staff trained by SLP on appropriate feeding techniques based on resident assessment/evaluation to prevent choking/coughing as well as potential negative outcomes that may occur. Re-training of all staff on the importance of monitoring of residents during meals was conducted on 9/28/2017 during scheduled Infection Control with addition of survey citations. Staff in-service provided regarding Plan of Correction and changes in process developed to address deficient practices as identified in survey of 9/18-22/2017. Ongoing monitoring and evaluation will be conducted by CNA Captain, Resident Care Managers and DON and presented and addressed at QAPI meetings to ensure compliance.	9/22/17 9/23/17 9/22/17 10/12/17 10/25/17 9/23/17 9/23/17 9/25/17 and Ongoing

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4 136	Continued From page 9 clean, dry, intact; 7/3/17 No new skin changes noted this shift. Wounds had been changed and assessed by Wound Nurse on day shift to bilateral hips. Darkened pressure sites to right lateral foot is present and open to air. Skin is intact. Dressings are clean, dry, intact; 7/10/17 No new skin issues noted at this time. On the morning of 9/21/17 at approximately 11:00 A.M. a review of the physician's history and physical (5/2/17) for Resident #19 noted he was admitted to the LTC facility for wound care and antibiotics (skilled nursing) then long term care. The physician's note dated 5/2/17 indicated Resident #19 eats well but required total assistance with feeding. She noted Resident #19 ate well but didn't gain weight. Resident #19's prealbumin level (necessary protein which is effected from malnutrition and helps practitioners determine a person's ability to recover from severe chronic illness) on 2/27/17 was 24 indicating a normal level (15-36). On 5/5/17, Resident #19's prealbumin level was 39.8. On 5/9/17 the physician noted Resident #19 had dehydration. The physician noted the nursing staff was providing pudding thick liquids even though Resident #19's order stated thin liquids. Starting around 6/11/17, Resident #19 began experiencing fevers and the physician's note dated 6/13/17 stated that Resident #19's left hip pressure injury appeared to be infected. The note stated Resident #19's left hip pressure injury was noted to have white material obscuring the view of the wound during the dressing change on 6/13/17 with purulent drainage and a foul odor. A wound culture was obtained and found to have [redacted] and Resident #19 was placed on contact isolation. A comprehensive review of all the physician's progress notes found she did not	4 136	Continued from Page 9 For Res # 166 a Speech evaluation was conducted on 9/20/17 with a recommendation made by the Speech Therapist to have food "chopped into ¾ -1" size and for nursing to assist resident with this. Per SLP evaluation, the resident required food "chopped" into bite size pieces due to resident's ADL issues and needing assistance by nursing staff. A review of the resident's chart was conducted on 9/25/2017 and 10/5/2017. On 9/23/2017 staff in-service were held with staff regarding the need to review resident care plans and importance of awareness of appropriate interventions to be provided to residents to ensure resident safety. On 9/25/2017 a review of the process for assessments/evaluation of residents with recommendations made by SLP, follow-up by nursing and Dietary was conducted. It was identified that residents were placed on "chopped" diets by SLP for residents with dysphagia/swallowing/chewing difficulties as well as preference when the residents had ADL difficulties and required the assistance of nursing staff to cut food into bite size pieces. Dietary was placing the preference order on the meal ticket as a reminder that nursing was to assist in the set-up/prep for residents with ADL difficulties. Reassessments were conducted by the SLP of all residents with similar conditions on 9/26-27/17 to differentiate residents placed on "chopped diets in ¾" to 1" " size from those requiring therapeutic diets due to swallowing/dysphagia Dx vs those with ADL issues and shared/reviewed by DON, Rehab Director, Administrator, Dietary Manager and Chef. Dietary huddles held on 10/5, 10/6, 10/9, 10/10 on new protocol/reminders/education in preparation of rollout/trial on 10/12/2017 of "universal" menu for residents requiring assistance/set-up/prep of meals due to ADL and/or chewing issues to ensure consistency in size. Residents were educated on the "universal" menu on 10/12/2017. Resident texture diet orders were updated on 10/9/17 with care plans and meal tickets updates completed. Discussions initiated with several local meat vendors with dietary in process of finalizing prices and negotiating product procurements based on facility needs for the new process.	9/25/17 9/23/17 9/25/17 9/26/17 thru 9/27/17 10/5/17 thru 10/12/17 10/9/17 10/12/17 10/12/17

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4 136	Continued From page 10 acknowledge that Resident #19: Developed a stage II pressure injury to his right hip on 6/8/17; and Developed two suspected deep tissue injuries to his right foot on 6/30/17. A review of the physician's notes dated 6/13/17 through survey date found she did not document assessments of Resident #19's wounds on his right hip and right foot. Additionally, the physician did not indicate the treatment plans for the new wounds or the fact that the wound on Resident #19's right hip deteriorated from a stage II on 6/8/17 to stage IV on 8/11/17. Interview of the Wound Nurse on the afternoon of 9/21/17 at 4:25 P.M. revealed Resident #19 was admitted to the LTC facility with a stage IV pressure injury on his left hip with the tendon showing. The Wound Nurse was asked whether the development of the stage IV pressure injury on Resident #19's right hip was avoidable. The Wound Nurse responded that the staff, including the Certified Nurses Aides (CNAs), were very focused on healing the resident's left hip wound. The Wound Nurse stated the staff were focused on offloading Resident #19's left side. He noted that from the frequent offloading of the left side, impaired skin integrity occurred on the right side. The Wound Nurse was asked if weekly skin assessments would demonstrate a breakdown in skin such as discoloration; redness; blanchiness; mushy feeling; or blisters prior to the development of a stage II pressure injury. The Wound Nurse stated that skin assessments would note such things as discoloration, redness, blanchiness, or blisters prior to breakdown to stage II pressure injury. The Wound Nurse was unable to explain how Resident #19's right hip was discovered at a stage II pressure injury without first having some visible skin breakdown prior to opening. The Wound Nurse reported the	4 136	Continued from page 10 To prevent recurrence of deficient practice and provide clarity to ensure understanding of diet orders/recommendations for residents with therapeutic diets due to swallowing/dysphagia Dx vs those residents requiring set-up/prep due to ADL issues the following will be implemented: 1. PCP orders for therapeutic orders for residents requiring textured diets due to Swallowing/dysphagia will be submitted for preparation, as indicated in care plan. 2. Residents requiring set-up/prep during meal service will be assisted by either RNAs or CNAs or LNs as per care plan interventions and indicated on meal ticket if there is a PCP order. 3. For those dishes requiring chopped meats and/or vegetables, Dietary will develop a "universal menu" that will meet the needs of all residents with bite size pieces of approximately ¾". Dietary contracted with vendor Kulana Foods to have all meats and/or vegetables cut into required sizes to ensure standardization in sizes. 4. Policies and procedures will be revised to address new process for both SLP and Dietary. 5. All resident care plans reviewed and updated ongoing. 6. Changes made to PCC EMR to allow for selection of "chopped" diet as ordered. 7. Ongoing training of staff will be provided to ensure understanding and compliance to new process. Will also be incorporated into new hire and annual staff training program. 8. Ongoing education of residents and/or resident representative regarding "universal" menu vs therapeutic diets vs set-up/prep process On 9/29/2017 during scheduled Infection Control and Pressure Injury training, review of survey citations and immediate implementation of corrective measures completed. Staff in-service provided regarding Plan of Correction and changes in process developed to address deficient practices as identified in survey of 9/18-22/2017. Ongoing monitoring and evaluation will be conducted by Rehab Director, Dietary, DON and presented and addressed at QAPI meetings to ensure compliance.	10/5/17 thru 10/13/17 9/29/17 9/23/17 9/25/17

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4 136	Continued From page 11 Hospice agency was able to provide Resident #19 with an air mattress at the end of June 2017, almost two months since his admission. When asked if the air mattress assisted with wound healing and potentially prevented development of pressure injuries, the Wound Nurse replied yes. He further noted they did not provide an air mattress for Resident #19 upon admission until he found out the Hospice would provide them. Resident #19's history of multiple pressure injuries, emaciated stature, and deteriorating health placed him at high risk for skin breakdown. Despite these risk factors, the facility failed to implement all necessary interventions to maintain the integrity of Resident #19's skin. The combination of Resident #19's risk factors and the lack of vital interventions resulted in the development of three new pressure injuries. One of the three wounds progressed from a stage II to a stage IV in a matter of 9 weeks. The physician failed to document any assessments or plans for the three facility acquired wounds. The facility's failure to maintain an aggressive approach to the prevention of additional skin breakdown resulted in Resident #19 developing a stage IV pressure injury on his right hip and two deep tissue pressure injuries on his right foot. 2) Resident #166 was admitted to the facility on 9/6/17. Diagnoses include the following: hypertensive urgency; dizziness and giddiness; chronic obstructive pulmonary disease with (acute) exacerbation; essential (primary) hypertension; gastro-esophageal reflux disease without esophagitis; and major depressive disorder. On 9/18/17 at 11:45 A.M. an interview was conducted with Resident #166. The resident	4 136	**Continued from Page 11** Legacy Hilo Rehabilitation and Nursing Center is committed to ensure that comprehensive resident centered are developed with integration of care/services provided by other agencies/entities are incorporated. For Res # 19 review of care plan was conducted and the following were identified: tasks to be provided by each entity was indicated, however there was no specific schedule of when hospice staff would be conducting their oversight/care, expectations and specific roles and responsibilities. On 9/21/17 meeting with Hilo Hospice Director and Legacy staff was held to discuss roles and responsibilities and the importance of collaboration. On 9/22/2017, the monthly schedule of RN and CNA visits was received with clear expectations and specific roles and responsibilities outlined. In July 2017 all care plans for hospice residents were reviewed and process for integration of hospice Plan of Care was initiated. Ongoing communication with hospice staff was conducted to discuss integration of services and scheduling. On 9/25/17 and ongoing; all care plans for residents with hospice services were reviewed and updated to ensure that integration of hospice services including respective staff schedule, expectations and responsibilities were incorporated. To prevent deficient practice from recurring the following has been implemented: a. Meetings with Hospice staff will be held on the 2nd Wed of each month to discuss issues/concerns and training need; b. Hospice Nurse to attend each care plan meeting and if not able to attend, will be sure to communicate with MDS Coordinator/RN with updates; c. Schedules of hospice staff with clear expectations and roles/responsibilities to be submitted to Legacy timely on a monthly basis for existing residents and at the time of admission and monthly thereafter for new residents d. Training by Hospice will be conducted quarterly to review philosophy and treatment modalities as well as responsibilities and collaboration with Legacy; e. At each on-site visit, Hospice RN to meet with Legacy LN to obtain current status update of resident, conduct visit/assessment, then at end of visit share with Legacy LN observations and any recommendations f. Hospice RN to document findings of visit into resident EMR g. Every Thursday skin assessments to be conducted by IP/Skin Care Coordinator and Hospice RN and documented. h. All residents admitted under Hospice care/services with wounds will be placed on air mattresses immediately. Staff in-service provided regarding Plan of Correction and changes in process developed to address deficient practices as identified in survey of 9/18-22/2017.	9/22/17 9/22/17 9/25/17 and Ongoing 9/25/17 and Ongoing 9/23/17

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4 136	Continued From page 12 reported difficulty swallowing due to loss of teeth and can only eat certain foods as it gets stuck in her throat when swallowing. On 9/20/17 at 1:41 P.M. Resident #166 reported she had difficulty eating her lunch today and had to ask the staff member to finely chop her food. She further stated she had difficulty swallowing the chicken that was in the chicken long rice that was served at lunch. The resident also reported she needs gravy on her foods to aid in swallowing. On the morning of 9/21/17 Resident #166 was observed with her breakfast tray on the bedside table. The resident reported she had eggs and toast. The toast was not cut into pieces, she reported she didn't eat one piece of toast as it was wet. Subsequent observation on 9/21/17 at 5:15 P.M. found the resident was served regular texture of chicken with gravy, rice and a slice of cake. The food items were not observed to be chopped into three-quarter to one inch pieces for consumption. On 9/20/17 at 1:51 P.M. a record review was done. The physician orders were reviewed and found an order with a start date of 9/16/17 for no added salt, regular texture and thin consistency. The physician also ordered speech therapy five times a week for three weeks for swallowing therapy, cognitive communication deficit and dysphagia. The speech therapy plan of care with the start date of 9/11/17 was provided on 9/2/17 at 3:00 P.M. The reason for referral included self-reported difficulty with swallowing with the patient reporting having difficulty with things "sticking" in her throat which appears to be getting worst. The therapist noted Resident #166 was seen with regular diet textures and thin liquids. The resident required the therapist to chop foods into three-quarter to one inch pieces	4 136	Continued from page 12 Ongoing monitoring and evaluation will be conducted by MDS coordinator/RN and DON and presented and addressed at QAPI meetings to ensure compliance. Legacy Hilo Rehabilitation and Nursing Center is committed to ensure that timely assessments are conducted to identify resident needs. For Res # 130, #2 and #120 chart reviews were conducted. It was identified that resident assessments as per Section C, D, E, Q were not conducted accurately. On 9/5/2017, during chart audit, it was identified that the resident assessment had not be completed. Re-in service of Social Services Designees was conducted to review process and RAI requirements. On 9/22/17 review of in-service provided on 9/5/2017 was conducted with Social Services designees re: the need to conduct all components of Section C, D, Q and E, and reiterated that if the resident is determined not competent to respond to questions, that Social Services designee will interview staff and/or resident representative to obtain pertain information and document appropriately in Section C, D, Q and E of MDS. Chart audits were conducted of all resident charts to ensure that timely assessments were conducted by DON and MDS RN. To prevent recurring practice from recurring ongoing audits will be conducted by Medical Records Health Information Manager and MDS Coordinator/RN. Staff in-service provided regarding Plan of Correction and changes in process developed to address deficient practices as identified in survey of 9/18-22/2017. Ongoing monitoring and evaluation to be conducted by Medical Records Health Information Manager, MDS Coordinator/RN and DON and presented and addressed during QAPI meetings to ensure compliance.	9/25/17 9/22/17 9/22/17 9/22/17 9/25/17 and Ongoing 9/22/17 9/25/17 and Ongoing 9/23/17 9/22/17 and Ongoing

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4 136	Continued From page 13 and to shred the beef. No coughing or throat clearing was observed but the resident seemed to make "effortful swallows approximately every 5 bites and reports sensation of 'sticking' in throat". The treatment diagnosis included dysphagia, unspecified (9/11/17) and cognitive communication deficit (9/11/17). The focus of therapy included treatment of swallowing dysfunction and/or oral function for feeding. A review of the task/kardex for the certified nurse aides was reviewed. There is no documentation that Resident #166 requires food to be chopped to three-quarter to one inch pieces. A review of the care plan provided on 9/21/17 at 5:35 P.M. notes a plan for nutrition risk related to a mechanically altered/therapeutic diet. Interventions included: per my speech-language pathologist chop my foods 3/4-1" pieces (9/20/17); provide my diet as ordered (9/20/17); and report coughing, choking, pocketing food, drooling or holding food in mouth to my nurse (9/15/17). On 9/21/17 at 5:15 P.M. an interview was conducted with Staff Member #51 and Staff Member #127 as they were passing out the dinner trays. Inquired whether Resident #166 requires any preparation for her meals. Staff Member #127 reported the resident doesn't like to eat steak because she has difficulty chewing. Further queried whether they are aware of the change to the resident's care plan to chop the food into three-quarter to one inch pieces. Both staff members responded they were not aware of any changes to the resident's care plan and further reported the resident is cognitive so they do not have concerns. On 9/21/17 at 5:17 P.M. an interview was conducted with Staff Member #59. Inquired whether he is aware of any	4 136	Continued from page 13 Resident # 70 a review of the resident chart was completed. Resident was admitted on 8/7/2017 with an admitting primary diagnosis of CVA I63.50 and "Encounter Palliative Care" Z51.5 ICD10. The 8/7/2017, physician encounter indicated assessment of resident completed and discussion held with family who wish to have resident remain at Legacy under "comfort care". On 8/8/2017 follow-up conducted by physician due to recurring aspiration pneumonia per nursing request, physician assessment was completed. Both 8/7/2017 and 8/8/2017 physician documentation notes were uploaded to the facility EMR on 8/11/2017. The resident passed away on 8/9/2017, and no care plan was developed for palliative or comfort care. A review of all admission diagnoses was completed and it was identified that no other residents were admitted to the facility with an admitting diagnosis of Palliative or Comfort care. To prevent recurrence of this deficient practice the following process has been implemented: 1. All admissions of residents with Diagnoses of Comfort or Palliative Care shall require a physician order at time of and/or prior to admission indicating that the "resident has a condition or chronic disease that may result in a life expectancy of less than 6 months". 2. Medical Director will place all admission assessments with applicable diagnoses and orders into "priority" tray in her office daily. 3. Medical Records personnel with make daily rounds to the Medical Director's office to ensure timely pick-up, and scanning/uploading to the EMR occurs. 4. Ongoing communication and dialogue with Admissions Coordinator, MDS Coordinator/RN and DON will occur. 5. Discussion with Secures was initiated on 10/13/2017 to discuss ability to scan documents with immediate upload to share drive feature to facilitate process and ensure timely access to medical director assessments, evaluations and orders. 6. MDS Coordinator/RN will ensure that all physician orders, assessments, evaluations are received and uploaded at the time of admission and review all documents timely to ensure that all necessary documentation are in place, to be able to inform staff of residents identified needs and complete baseline care plan within 48 hours of admission. 7. MDS RN reviews and sign all assessments. Re-training of Admissions Coordinator, MDS Coordinator, Medical Records personnel, Medical Director regarding the importance of timely submittal/upload/review of all admission documents to ensure that residents' needs are addressed and a baseline care plan is in place as per applicable requirements. Ongoing monitoring and evaluation will be conducted by Admissions Coordinator, MDS Coordinator/RN, Medical Records Health Information Manager and DON and presented and addressed at QAPI meetings to ensure compliance	9/25/17 9/25/17 9/25/17 and Ongoing 9/25/17 9/25/17 and Ongoing

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4 136	Continued From page 14 changes to the resident's care plan, the staff member acknowledged not being aware of changes to the resident's care plan. The facility failed to ensure Resident #166's care plan was implemented to address her problems with swallowing (dysphagia) to attain her highest physical and psychosocial well-being. 3) Resident #19 was reviewed for hospice services during stage 2 of the QIS survey. Resident #19 was admitted to the Long Term Care (LTC) facility on 5/1/17 for stage IV pressure injury wound care and long term care. He was admitted to hospice services on 5/12/17 when the physician noted Resident #19 had a poor prognosis for a full recovery. The collaboration of services (including supplies) between agencies was not clear and the LTC facility was unable to describe a coordinated end of life plan of care for Resident #19. A review of Resident #19's care plan noted a focus for hospice care. The interventions included: Hospice nurse visits once per week or more if needed; MSW visit once per month; Spiritual visits once per month; Hospice nurse is to be notified first of any changes; and Name and address of the hospice agency. An interview of a Nurse Consultant on the afternoon of 9/20/17 at 3:27 P.M. found her understanding was the Hospice agency was involved in the care plan. When asked to demonstrate how the care plan is coordinated between the agencies, the Nurse Consultant directed the Surveyor to the nurses station where a binder contained the collaborated care plan between the Hospice and LTC facility. The binder	4 136	4 136 Resident Care See pages 6-14	

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4 136	Continued From page 15 at the nurses station did not contain a collaborated care plan but rather the Interdisciplinary Team meeting plan of care completed by the Hospice agency. An interview of a CNA on the afternoon of 9/20/17 at 3:40 P.M. revealed she was unaware that Resident #19 was receiving Hospice services. An interview of the MDS Coordinator on the afternoon of 9/20/17 at 3:50 P.M. revealed the facility and hospice agency did not have a collaborative end of life plan of care for Resident #19. The MDS Coordinator noted that as the LTC facility, "We do everything". She noted the LTC provided all the wound care, Activities of Daily Living (ADL) care, and all other things Resident #19 requires for his care. The MDS Coordinator stated the Hospice agency provided supplies for wounds, bedside commode, or any other special equipment a resident would need for end of life care. When asked if the Hospice provided Certified Nurses Aide (CNA) services, the MDS Coordinator stated yes. However, she was unable to describe what the Hospice CNAs did for Resident #19 during their visits. The MDS Coordinator was unable to show Surveyor the Hospice CNA's progress notes. An interview of the Director of Nurse (DON) on the afternoon of 9/20/17 at 3:30 P.M. revealed the Hospice CNAs did not shower any of the LTC facility's residents. The DON noted the Hospice CNAs provided personal care such as grooming and hair washing. The DON's understanding of the Hospice Nurses' roles was to assess the resident and update physician's orders. The DON stated that all care is provided by the LTC facility. The DON confirmed that the LTC facility's care plan does not integrate the hospice's care	4 136	4 136 Resident Care See pages 6-14	

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4 136	Continued From page 16 plan for residents receiving the hospice benefit. A review of Resident #19's Minimum Data Set, MDS, with Assessment Reference Date, ARD, of 5/12/17 noted it was a significant change assessment. Resident #19 was admitted to hospice on 5/12/17. However, under Section J Health Condition, item J1400 Prognosis, "Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? No." An interview of the MDS Coordinator on the afternoon of 9/20/17 at 3:50 P.M. revealed the MDS with ARD 5/12/17, item J1400 was incorrect and should have been answered "Yes". On the morning of 9/22/17 a review of the LTC facility's agreement with the Hospice found the following: The Plan Of Care (POC) will reflect the participation of the Hospice, Facility and the Hospice Patient and family to the extent possible. The POC includes: (i) an identification of the Hospice services, including interventions for pain management and symptom relief, needed to meet such Hospice patient's needs and the related needs of Hospice patient's family; (ii) a detailed statement of the scope and frequency of such Hospice Services; (iii) measurable outcomes anticipated from implementing and coordinating the Plan of Care; (iv) drugs and treatment necessary to meet the needs of the Hospice patient; (v) medical supplies and appliances necessary to meet the needs of the Hospice patient, and (vi) the IDT's documentation of the Hospice Patient's or representative's level of understanding, involvement and agreement with the Plan of Care. Hospice and Facility will jointly develop and agree upon a coordinated Plan of Care which is consistent with the hospice philosophy and is responsive to the unique needs	4 136	4 136 Resident Care See pages 6-14	

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4 136	Continued From page 17 of Hospice Patient and his or her expressed desire for hospice care. The facility failed to provide a collaborative end of life plan of care for Resident #19 to maintain his highest practicable physical and psychosocial well being.	4 136	4 136 Resident Care See pages 6-14	
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on observation, record review and interview with staff members, the facility failed to	4 149	4 149 Nursing Services Cross reference with 4 136 See Pages 6-14	

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4 149	Continued From page 18 ensure caregiving staff are aware of the services required as outlined in the resident's comprehensive care plan for Resident #166. Findings include: Cross Reference to F309. Resident #166 was admitted to the facility on 9/6/17. Speech therapy was ordered by the physician for swallowing therapy and a diagnosis of dysphagia. The speech therapist assessed and revised the resident's care plan on 9/20/17 to include chopping of the food into three-quarter to one inch pieces. Interview with Staff Members #59, #51 and #127 during the dinner meal on 9/21/17 at 5:15 P.M. found these direct caregivers were aware of the resident's difficulty with chewing; however, not aware the revision to the care plan on 9/20/17 resulting in the lack of implementing the interventions to address the dysphagia. The facility failed to ensure Resident #166's direct caregivers were made aware of the resident's care plan and the services required for dysphagia.	4 149	4 149 Nursing Services Cross reference with 4 136 See Pages 6-14	
4 160	11-94.1-41(b) Storage and handling of food (b) Effective procedures to promptly and consistently clean all equipment and work areas shall be enforced. This Statute is not met as evidenced by: Based on observation and interview with staff member, the facility failed to prepare food in a	4 160	4 160 Storage and Handling of Food Legacy Hilo Rehabilitation and Nursing Center is committed to ensure that all equipment in the dietary area is clean and a sanitary environment is maintained. On 9/21/2017, fan was removed from prep/serving area and cleaned by housekeeping. To prevent this deficient practice from recurring, a preventive maintenance cleaning schedule has been implemented for monthly cleaning of all equipment within the kitchen area by housekeeping. On 9/29/2017 during scheduled Infection Control training, review of survey citations and immediate implementation of corrective measures completed. Staff in-service provided regarding Plan of Correction and changes in process developed to address deficient practices as identified in survey of 9/18-22/2017. Ongoing monitoring and evaluation will be conducted by the Dietary Manager, Chef and Housekeeping supervisor to ensure compliance with presentation and review at QAPI meetings.	9/21/17 9/22/17 and Ongoing 9/29/17 9/23/17 9/22/17 and Ongoing

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4 160	Continued From page 19 sanitary environment. Findings include: On 9/21/17 observation in the kitchen during lunch preparation found a black fan placed on the floor which was blowing air to the prep area of the kitchen. Staff Member #34 was asked to turn the fan off. When the fan was turned off, the staff member stated there is dust on the fan grill and propellers, the staff member removed the fan from the kitchen. The facility failed to maintain a sanitary environment as evidenced by a dusty fan blowing in the food preparation area.	4 160	4 160 Storage and Handling of Food See page 19	
4 192	11-94.1-46(i) Pharmaceutical services (i) Appropriately licensed and trained staff shall be responsible for the entire act of medication administration, which entails removing an individual dose from a container properly labeled by a pharmacist or manufacturer (unit dose included), verifying the dosage with the physician's orders, giving the specified dose to the proper resident, and promptly recording the time, route, and dose given to the resident, and signing the record. Only a licensed nurse, physician, or other individual to whom the licensed professional has delegated the responsibility pursuant to chapter 16-89, subchapter 15, may administer medications. This Statute is not met as evidenced by: Based on observations and staff interviews, the facility failed to properly administer medications	4 192	4 192 Pharmaceutical Services Legacy Hilo Rehabilitation and Nursing Center is committed to ensure that medications are administered accurately and as ordered by PCP. 9/23/17 LNs were in-serviced on the proper application of inhalers, by providing a cup of water to the resident to rinse his/her mouth immediately after inhalation. When more than one inhaler is administered, LN shall provide the resident with water after the use of the last inhaler. Educated staff re: the need to ensure that medications will be administered accurately and as ordered by PCP. Medication pass training provided by Pharmacist to all licensed staff including Staff Development RN. To prevent recurrence of deficient practice Pharmacist and Staff Development RN will conduct quarterly med pass reviews/audits alternately, to ensure compliance and competency validation. Staff in-service provided regarding Plan of Correction and changes in process developed to address deficient practices as identified in survey of 9/18-22/2017. Ongoing monitoring and evaluation will be conducted by Staff Development RN and DON to ensure compliance and resident with presentation and review during QAPI meetings.	9/23/17 Scheduled 10/27/17 and Ongoing Scheduled 10/27/17 and Ongoing 9/23/17 Ongoing

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4 192	Continued From page 20 resulting in a medication error. Findings include: An observation of Staff #143 administering medication on the morning of 9/21/17 found medication errors. Staff #143 was observed administering medications to Resident #161 in which he received the following: Spiriva HandiHaler Capsule 18 mcg Inhaler, Inhale contents of 1 cap via HandiHaler daily, Rinse mouth with water after administration; Incruse Ellipta Aerosol Powder Breath Activated 62.5 mcg Inhaler, Inhale 1 puff daily, Rinse mouth with water after administration; Symbicort Aerosol 160-4.5 mcg Inhaler, Inhale 2 puffs twice daily, Rinse mouth with water after administration. After giving Resident #161 with his Spiriva HandiHaler inhaler, Staff #143 asked Resident #161 to sip some orange juice. After giving Resident #161 with his Incruse Ellipta inhaler, Staff #143 asked Resident #161 to sip some orange juice. After giving Resident #161 with his Symbicort inhaler, Staff #143 asked Resident #161 to sip some orange juice. When she completed her medication administration with Resident #161, Staff #143 was asked if the resident was supposed to rinse his mouth with water after each inhaler. Staff #143 reported that was the reason she gave Resident #161 orange juice between each inhaler. An interview of the Director of Nursing, DON, on the morning of 9/21/17 at 10:00 A.M. revealed that her expectation was the nurses were expected to follow the physician's orders and rinsed Resident #161's mouth with water after each inhaler. The facility failed to properly administer Resident	4 192	4 192 Pharmaceutical Services See page 20	

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4 192	Continued From page 21 #161's inhaler medications resulting in a 12% medication error.	4 192	4 192 Pharmaceutical Services See page 20	
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure a safe, sanitary environment for residents. Findings include: 1) An observation of dressing change for Resident #19 on the morning of 9/21/17 at 9:30 A.M. found Staff #3 assisting the Wound Nurse. The Wound Nurse set up his dressing change supplies on Resident #19's bedside table by first laying down a waterproof barrier over the surface. The waterproof barrier extended over the sides of the bedside table, where it folded over the edges. The Wound Nurse went to the sink to wash his hands and asked Staff #3 to wash his hands as well. Staff #3 washed his hands, removed clean gloves from a box, then used the clean gloves to lift the lid of the trash can. Staff #3 then placed the same gloves on his hands; put on a disposable gown with the gloves on; touched his face; went over to the bedside and with the same gloves, placed both hands on both sides of the	4 203	4 203 Infection Control Legacy Hilo Rehabilitation and Nursing Center is committed to ensure that an effective infection prevention and control program is implemented. Can of thickener with scoop was discarded on 9/22/2017. On 9/23/2017, in-service held with staff and informed that a clean disposal medication cup is to be used and discarded after each use. To prevent this deficient practice, from recurring, all canned thickeners were removed from the Med Carts and replaced with single-dose packets of thickeners of nectar and honey consistency. Training was provided to all staff regarding appropriate use of packet thickeners that are labelled accordingly, as per manufacturer's directions. On 9/28/2017, Dietary added purchase of single-dose packets to their purchase orders to ensure ongoing supply for use. At this time, residents requiring thickened liquids are for honey or nectar consistency. Should other consistencies be required, adjustments will be made to meet those requirements. On 9/29/2017 during scheduled Infection Control training, review of survey citations and immediate implementation of corrective measures completed. Staff in-service provided regarding Plan of Correction and changes in process developed to address deficient practices as identified in survey of 9/18-22/2017. Ongoing monitoring and evaluation will be conducted by Medication Nurse, Resident Care Manager and DON, to ensure compliance with presentation and review at QAPI meetings to ensure compliance. On 9/23/17 during in-service review of safe infection control practices was conducted with staff. A review of the Infection Prevention and Control policies and procedures was conducted to ensure accuracy and compliance with CDC/CMS requirements. To prevent deficient practice from recurring the following was implemented: 1. Scheduled mandatory in-service training on infection control held on 9/29/2017 with written test given after training to determine staff understanding/knowledge 2. Weekly audits to be conducted by CNA Captain of all direct care staff and documented 3. Monthly audits will be conducted monthly of all LNs during provision of wound care by IP/Skin Care Coordinator and documented 4. Quarterly audits which would encompass infection control during Med Pass audits to be conducted by Staff Development RN and documented	9/22/17 9/23/17 9/25/17 and Ongoing 9/29/17 9/23/17 Ongoing 9/23/17 10/5/17 Ongoing

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4 203	Continued From page 22 bedside table with the clean field and clean supplies and proceeded to move the table to the other side of the bed. Staff #3 then returned to the other side of the bed to assist the Wound Nurse with turning Resident #19. After cleaning Resident #19's left hip wound, the Wound Nurse removed his gloves, washed his hands and donned clean gloves. The Wound Nurse instructed Staff #3 to wash his hands as well. Before removing his contaminated gloves, Staff #3 again touched the clean field by placing both hands on the overlapping waterproof barrier and moving the bedside table over to the other side of the bed. Staff #3 then washed his hands, dried them, and used the paper towels to lift the trash can lid but his bare hand touched the lid of the biohazard trash bin next to it. He then reached for clean gloves and placed them on his hands. An interview of the Wound Nurse on the morning of 9/21/17 at 10:00 A.M. revealed Staff #3 should have re-washed his hands after touching the trash can lids. The Wound Nurse also confirmed that Staff #3 should have taken another set of clean gloves rather than use the ones he used to touch the trash can lid. 2) On 9/21/17 at 6:55 P.M. concurrent observation with Staff Member #29 of the medication cart found a can of Thick and Easy with the scooper stored in the powder. The staff member reported the procedure when preparing a thickened drink includes washing of the hands, removal of the scooper and replacing the scooper. Further queried how do you assure all staff member are implementing this practice. The staff member acknowledged the potential and stated the scooper will be removed and in placed	4 203	Continue from page 22 Ongoing monitoring and evaluation to be conducted by CNA Captain, IP/Skin Care Coordinator, Staff Development RN and DON with presentation and review to be conducted during QAPI meetings to ensure compliance.	9/25/17 and Ongoing

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4 203	Continued From page 23 in a plastic bag. The staff member was observed to open the can and remove the plastic scooper from the container. No hand sanitizing or washing was observed prior to the removal of the scooper.	4 203	4 203 Infection Control See page 21-23	