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
	125007	A. BUILDING: _____ B. WING _____	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MAKUA - KAHULUI	472 KAULANA STREET KAHULUI, HI 96732

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4 000	Initial Comments A recertification and relicensure survey was conducted on October 23-26, 2017. On entrance to the facility the census was 207.	4 000	The submission of this plan of correction does not constitute an admission with the allegations of non-compliance. It is submitted solely as the facility's credible allegation of compliance as mandated by Federal and State regulations.	
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on interviews the faility failed to ensure residents were treated in a respectful and dignified manner for one out of 26 Stage 2 residents. Findings: During an interview with Resident # 98's husband on October 23, 2017 he stated that staff #-- quite often would speak to his wife and himself in a disrespectful manner. He went onto say this has occured on many occassions and that he and his wife find the manner in which they are spoken to by staff #-- offensive. He also stated he would ask staff #-- to do things for his wife in a particular manner and that staff #-- would not do so. He	4 115	It is the policy of Hale Makua Kahului that each resident is treated as an individual with dignity and respect. **4 115 Resident rights and facility practices** **Corrective Action** This facility will ensure that each resident is treated with dignity and respect. Facility event report was created on 10/23/17 regarding Resident #98 concerns. Certified Nursing Assistant was removed from care of Resident #98 on 10/25/17. Certified Nursing Assistant provided with 1-1 education on resident dignity on 12/6/17. Resident #98 care plan updated on 11/20/17 to include resident blanket placement preference. This facility will also continue to ensure all residents have the right to make choices about aspects of his or her life that are significant.	

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4 115	Continued From page 1 used an example of asking staff #-- to fold the blanket down on his wife's bed in a particluar way so that it was easy for her to pull it up when she needed it. Staff # --proceeded to fold the blanket into a small square and place at the end of her bed that would make it difficult for her to reach when she needed it. During another interview with Resident #98's husband on October 25, 2017, he continued to express his concerns about staff #-- manner in which he speaks to both himself and his wife and the blanket incident. Based on interviews with residents and staff members, the facility failed to ensure a resident has a right to make choices about aspects of his or her life that are significant to the resident for 3 (Residents #53, #248 and #180) of 15 residents interviewed. Findings include: 1) On 10/23/17 at 1:15 P.M. an interview was conducted with Resident #248. The resident was asked whether she is able to choose how many times a week a bath or shower is provided. The resident responded she receives showers twice a week, Mondays and Thursdays. Resident #248 clarified her preference would be for three times a week. A record review was completed on 10/26/17 at 8:15 A.M. A review of the admission Minimum Data Set (MDS) with assessment reference date (ARD) of 2/16/17 notes in Section F0400. Interview for Daily Preferences, Resident #248 reported it is very important to choose between a tub bath, shower, bed bath or sponge bath. The resident's care plan for Activities of Daily Living Assistance notes the resident prefers a shower. A subsequent quarterly MDS with an ARD of	4 115	Resident #248 preference for choice of bathing schedule was updated on 10/26/17. Resident #53 preference for choice of bathing schedule was updated on 12/5/17. Resident #180 preference for choice of bathing schedule was updated on 10/26/17. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. **Responsible Person** The Director of Nursing and Nurse Supervisors will be responsible for on-going compliance. **Systemic Changes and Monitoring** All staff will be in-serviced by 12/19/17 on facility Policy & Procedure (P&P) on Resident Rights. All staff will be in-serviced by 12/19/17 regarding resident choices and preferences, including but not limited to bathing schedules. Facility staff conducted house wide audit on resident bathing preferences beginning 11/13/17. Audit will be complete by 12/31/17 with updated care plans accordingly.	

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4 115	Continued From page 2 8/17/17 documents, Resident #248 yielded a score of 13 (cognitively intact) when the Brief Interview for Mental Status was administered. On 10/25/17 at 10:00 A.M. an interview was done with Staff Member #114. Inquired how the facility determines the frequency of showers a resident receives. The staff member reported during the first family meeting the facility offers showers twice a week and bathing frequency is discussed. The families are asked how often the resident received showers at home or the resident will be asked if they want more showers. The staff member also reported families and residents are periodically asked about the frequency of showers, usually during the quarterly assessments. On 10/26/17 at 8:20 A.M. Staff Member #113 was asked to provide documentation of the discussion related to frequency of showers during the admission and subsequent quarterly review. Subsequently an interview was done with the Assistant Director of Nursing (ADON) at 8:34 A.M. The ADON reported residents or their representatives are asked their preferences (evening or afternoon) and frequency for bath/shower. The residents or their representatives are asked at the time of admission and periodically during their quarterly reviews. A request was made to the ADON to provide documentation of the facility's discussion with the resident or the representative related to baths/showers. On 10/26/17 at 9:35 A.M., Staff Member #113 reported a review of Resident #248's electronic record found there is no documentation at admission or subsequently related to asking the resident's preference for the frequency of	4 115	Bathing preference questions will be asked upon admission and quarterly at Resident Care Conferences. Interdisciplinary team will conduct monthly Facility Focus Rounds to ensure that all residents are being offered a choice on their bathing/showering preferences. Interdisciplinary team will conduct monthly Facility Focus Rounds to ensure that resident rights are being addressed. Event reports will be initiated for any resident care issues. Any issues will be reported to morning stand-up and discussed in monthly Quality Assurance and Performance Improvement (QAPI) committee meetings/ **Date of Correction** Compliance will be met by 12/19/17 and on	12/19/17

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4 115	Continued From page 3 baths/showers.	4 115		
4 120	1-94.1-27(9) 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: (9) The right to names, addresses, and telephone numbers of pertinent resident advocacy groups; This Statute is not met as evidenced by: Based on observation and interviews with resident and staff member, the facility failed to ensure names, addresses and telephone numbers of all pertinent State and advocacy group is posted in a form and manner accessible to residents and resident representatives. Findings include: The resident council interview was done on the afternoon of 10/25/17. The resident representative identified a staff member as the Ombudsman and was not aware the State Agency could be contacted for complaints. Inquired where the posting is located, the representative pointed to the side of nursing station, stating there is a bulletin board located there with the information. Observation found there is no bulletin board for the residents outside of the nurses' station. Further observation found two bulletin boards, one located on the wall	4 120	**4 120 Resident rights and facility practices** **Corrective Action** This facility will be sure to post contact information for the State Long-Term Care Ombudsman in an accessible area. State Long-Term Care Ombudsman contact information was enlarged to size 24 font and printed on bright green paper and placed at eye level, in bulletin board cases outside Administrators office and Social Services office on 10/27/17. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. **Responsible Person** The Social Services Director will be responsible for on-going compliance.	

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4 120	Continued From page 4 outside of the Weinberg Family room and a second bulletin board on a wall outside of the social services office. The information for the telephone number and address of the State Agency was printed on an 8-1/2 by 11 inch paper and tacked on the second row of the information posting. The print and placement were noted to make it difficult for a resident seated in a wheelchair to review. On 10/25/17 at 4:00 P.M. concurrent observation and interview was conducted with Staff Member #324. Staff Member #324 confirmed there are two bulletin boards in the entire facility. The staff member confirmed the information posted on both boards would be too high for residents in wheelchairs to view the information. The staff member also acknowledged the print was small which would be difficult for residents with visual impairment and/or seated in the wheelchair to read.	4 120	**Systemic Changes and Monitoring** State Long-Term Care Ombudsman contact information was enlarged to size 24 font, printed on bright green paper and placed in each bulletin board case at resident eye level on 12/8/17. Bulletin board cases are located at main entrance outside HR, outside Social Services Dept., outside Administrators office, and between East and Gardenia neighborhoods. State Long-Term Care Ombudsman contact information was enlarged and printed on a bright green paper and placed on resident designated bulletin boards on each neighborhood on 12/8/17. Activities Director will audit resident awareness of location of Ombudsman contact information monthly during resident council meeting for the next 3 months to ensure compliance. Results will be reported to QAPI monthly.	
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:	4 159	**Date of Correction** Compliance will be met by 12/8/17 and on an ongoing basis. **4 159 Storage and handling of food** **Corrective Action** This facility will ensure that proper food handling practices to prevent the outbreak of foodborne illnesses.	12/8/17

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4 159	Continued From page 5 Based on observations and staff interviews the facility failed to ensure proper food handling practices to prevent the outbreak of foodborne illness. Findings include: On 10/23/2017 at 10:15 AM during the initial kitchen tour with Staff#163, observed that the bread storage rack had brown plastic trays to place the bread loaves on and the brown racks were discolored with blackish residue. According to Staff#163 the bread company provided the bread rack and can probably provide a new rack. The walk-in refrigerator #4 contained 4 packages of sliced Swiss cheese with expiration date of 10/07/17 and cole slaw and creamy Italian dressing with no expiration dates. Staff#163 removed the items at that time. The facility did not follow food handling practices to prevent the outbreak of foodborne illness.	4 159	All food items identified (Swiss cheese, coleslaw, and creamy Italian dressing) were immediately disposed of on 10/23/17. Bread rack was cleaned on 10/23/17. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. **Responsible Person** Dietary Manager will be responsible for on-going compliance. **Systemic Changes and Monitoring** Staff education was done from 12/5/17-12/6/17 which included review of facility P&P titled Food Storage. All food in refrigerator or frozen storage will be labeled and dated to ensure proper food storage as well as food quality. Dietary Manager will do daily checks of all food items stored in refrigeration and freezer units for 90 days or until 100% compliance. Interdisciplinary Team will conduct monthly focus rounds to ensure facility P&P is met regarding food labeling and dating and kitchen cleanliness. Any and all issues will be reported to daily stand up	
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,	4 192		

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4 192	Continued From page 6 subchapter 15, may administer medications. This Statute is not met as evidenced by: Based on observations, medical record review, staff interview and facility policy review, the facility failed to ensure that the medication regimen for one of five residents, Residents #234, was closely monitored for mood and behaviors. Findings include: Resident #234 was admitted to the facility on 9/1/17 with diagnoses which included displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, and chronic kidney disease. Resident #234 had a physician's order (10/12/17) for Risperdal 0.25mg tab daily for diagnosis of dementia with behaviors as evidenced by restlessness and agitation. The facility did not provide routine mood and behavior monitoring for Resident #234, making it unclear why he was receiving an antipsychotic medication. A review of Resident #234's medical record on the afternoon of 10/25/17 revealed no documentation of behaviors in the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/8/17 (Admission). A review of the nurse's notes did not find notes titled "Behavior" or any documentation that indicated he was experiencing mood/behavior issues. Additionally, the facility was not routinely monitoring Resident #234's behaviors. On the afternoon of 10/25/17, a review of a form titled, "Behavior Monitoring", dated 10/19/17 revealed Resident #234: Did not display moods during the monitoring period; No behavior symptoms displayed during the	4 192	meeting as well as discussed monthly at Quality Assurance Performance Improvement Committee (QAPI) meetings. **Date of Correction** Compliance will be met by 12/6/17 and on an ongoing basis. **4 192 Pharmaceutical services** **Corrective Action** This facility will ensure that its residents are free from any unnecessary drugs and that residents are closely monitored for mood and behaviors. Resident #234 order clarification was obtained on 12/7/17. Medication indication was added on 12/7/17. Education provided to Staff #46 regarding mood and behavior monitoring policy done on 12/7/17. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency.	12/6/17

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4 192	Continued From page 7 monitoring period; Resident was currently taking psychotropic medications to address mood/behavior symptoms; Current medications are effective in alleviating mood and/or behavior symptoms; No psychotropic side effects observed during the monitoring period; There's a current plan of care with intervention to address the resident's mood and/or behavior symptoms; The interventions in place are effective for the resident's mood and/or behavior symptoms. The form further noted the monitoring frequency was to continue weekly monitoring. The rationale for monitoring frequency was left blank. An interview of Staff #46 on the afternoon of 10/25/17 at 3:53 P.M. found Resident #234 had been transferred to his current unit from another unit in the facility on 10/17/17. Staff #46 reported the resident was doing okay during the evening shifts until 10/24/17. She reported Resident #234 experienced hallucinations on the evening of 10/24/17 when he was distressed and reported seeing his foot detached from his body. Staff #46 further noted the resident was attempting to lift the table to pick up his "detached leg" from under the table. She informed Resident #234 she didn't see anything and turned his wheelchair around. The resident then attempted to hit the Certified Nurses Aide (CNA) who was standing behind his wheelchair. The resident then attempted to stand and climb over his foot rest. Staff #46 stated that it became unsafe as Resident #234 almost tripped over his foot rest. Staff #46 reported Resident #234's behaviors to the physician and an order was placed for Risperdal 0.25mg every 8 hours as needed for restlessness, hallucinations, and difficulty to redirect. Staff #46 was asked where she documented Resident #234's behaviors. She replied she did not document the behaviors on the evening of	4 192	**Responsible Person** Director of Nursing and Nurse Supervisors will be responsible for on-going compliance. **Systemic Changes and Monitoring** In-services were provided to nursing staff from 12/13/17-12/19/17 regarding proper documentation in EMR. Policy and Procedure updated to reflect continuous daily monitoring of any resident with behaviors and any resident on a Psychotropic medication. Nurse Supervisors will conduct daily audits of orders to physician to ensure proper documentation of mood and behaviors. Any identified issues will be corrected immediately. Health Information Manager will conduct weekly audits of MAR/TAR documentation to identify any issues with inaccurate documentation by LN's in the EMR. Any identified issues will be corrected immediately. Monitoring will be ongoing for 90 days or until 100% compliance. **Date of Correction** Compliance will be met by 12/19/17 and on an ongoing basis.	12/19/17

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4 192	Continued From page 8 10/24/17 and stated, "but I can do a late entry". When asked what the facility's policy was for monitoring residents' behaviors, Staff #46 stated, "I don't know the policy". A review of Resident #234's care plan found one for the use of antipsychotic medication related to delirium. Interventions included, "Evaluate indications for usage of antipsychotic medications including specific behaviors and effect of behaviors on resident and/or others. Identify target behaviors and document in clinical record." An interview of Staff #113 on the afternoon of 10/25/17 at 3:55 P.M. found her understanding of behavior monitoring was initial monitoring occurred when a resident was new to the facility, had newly identified mood/behaviors, or changes in psychotropic medications. This initial monitoring was done every shift for one week. After the first week, the nurses monitored residents weekly for a total of 8 weeks. After the eighth week, the staff would discontinue behavior monitoring. When asked about Resident #234's behaviors on the evening of 10/24/17, Staff #113 reported they hadn't followed the facility's policy of monitoring behavior every shift after a change in Resident #234's psychotropic medications. Additionally, Staff #113 reported that Staff #46 should have entered a nurse's note for Resident #234's behavior on the evening of 10/24/17. An interview of the Assistant Director of Nursing (ADON) on the morning of 10/26/17 at 8:20 A.M. revealed the facility started (10/19/17) routine behavior monitoring for any resident on psychotropic medications. The ADON reported the facility was changing their policy to include mood and behavior monitoring every shift for as long as the resident was receiving psychotropic	4 192		

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4 192	Continued From page 9 medications. The ADON further noted that since this is a recent change in their policy, not all nurses are aware. The ADON reported that Resident #234 should be monitored for behaviors every shift for as long as he is on psychotropic medications. A review of the facility's policy titled, "Mood and Behavior Management Policy and Assessment Procedure" with revision date of 2/16 noted, "B. Routine Behavior Monitoring: 1. Initiation of new psychotropic medications or changes (whether *increasing or decreasing) in current dosage of* psychotropic medications is made." The facility failed to closely monitor and document Resident #234's behaviors, making it unclear for the rationale of using an antipsychotic medication.	4 192		
4 196	11-94.1-46(m) Pharmaceutical services (m) Drugs for external and internal use shall be kept separate and stored in locked, well-marked, separate cabinets. This Statute is not met as evidenced by: Based on observations, staff interview and facility policy review, the facility failed to properly label and store medications. Findings include: During a review of medication storage on two of the six units in the facility on the morning of 10/25/17 at 10:43 A.M. found multiple bottles of medications which were incorrectly labeled and/or stored:	4 196	**4 196 Pharmaceutical services** **Corrective Action** This facility will ensure to properly label and store medications. Identified medications were discarded immediately on 10/25/17. Pharmerica was notified on 10/25/17 of medications with improper labels or with labels rubbed off. Alcohol wipes with expiration dates on each pad were purchased and delivered to all neighborhoods on 12/11/17.	

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4 196	Continued From page 10 1) Artificial Tears Solution which noted it was opened on 8/10/17. Staff #80 reported the facility's policy was to discard eye drops 60 days after it was opened (10/10/17). Additionally, the medication was discontinued on 9/1/17 but the bottle was still being stored in the medication cart. 2) Artificial Tears Solution which was opened on 10/6/17. The pharmacy label covered the bottle's expiration date and the label did not contain an expiration date. 3) Artificial Tears Solution with a label which noted the prescription was filled on 7/24/17. Staff #80 reported the bottle had been opened but the opened date was not written on the bottle. Staff #80 was unsure of when the bottle should be discarded. 4) Artificial Tears Solution which was opened on 9/12/17. The pharmacy label was blank as though the words were rubbed off - no name, medication name or prescription fill date could be visualized on the label. The manufacturer label noted the expiration date of 2/2020. 5) Artificial Tears Solution which was opened on 10/25/17 but the expiration date of the medication was covered by the pharmacy label. 6) Dorsolamine HCl Ophthalmic Solution with a pharmacy label which was blank as though the words were rubbed off. Additionally, the eye drops were opened on 8/16/17 indicating an expiration of 10/16/17, 60 days since opened. 7) Artificial Tears Solution which was opened on 9/17/17. The pharmacy label covered the bottle's expiration date.	4 196	No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. **Responsible Person** The Director of Nursing and Nurse Managers will be responsible for on-going compliance and education of staff on medication administration procedures, including those related to disposition. **Systemic Changes and Monitoring** In-services were provided to nursing staff from 12/13/17-12/19/17. Nurse Managers will continue with annual medication administration competency for all licensed nurses. Beginning 12/5/17, Licensed Nurses will conduct daily audits of medication carts and medication rooms to ensure: 1) proper disposition of all expired medications, and 2) proper labeling and dating of medications, for 90 days or until 100% compliance. Any and all issues will be reported to daily stand up	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125007	A. BUILDING: _____ B. WING _____	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MAKUA - KAHULUI	472 KAULANA STREET KAHULUI, HI 96732

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4 196	Continued From page 11 8) Haloperidol 1mg tab which was individually wrapped and did not contain a label. The expiration date was 5/2017. 9) Tuberculin PPD Solution which was opened on 9/18/17 was found in the medication refrigerator. Staff #80 noted that PPD Solution should be discarded 30 days after opening (10/18/17). 10) Alcohol Wipes - 5 boxes containing 200 wipes in each did not have expiration dates on the boxes or the individual packets. Staff #80 stated the expiration may have been on the larger box they were shipped in. However that larger box had already been discarded. Staff #80 stated she wasn't sure if the alcohol wipes were effective since there wasn't an expiration date. On the morning of 10/26/17 at 8:20 A.M., a review of the facility's policy titled, "Medications and Medication Labels" with revision date of 5/16 noted: "1. Each prescription medication will be labeled to include: h. Expiration or end-of-use date, if not dispensed in original manufacturer packaging"; "4. The provider pharmacy permanently affixes label to the outside of prescription containers. Medication labels are not inserted into vials, bags or other containers. For medications designed for multiple administration (for example, inhalers or eye drops), a label is affixed to product to assure proper resident identification"; and "5. Non-prescription medications not labeled by the pharmacy are kept in the manufacturer's original container. Nursing care center personnel may write the resident's name on the container or label as long as the required information is not covered, if applicable by state regulations."	4 196	meeting as well as discussed monthly at Quality Assurance Performance Improvement Committee (QAPI) meetings. Pharmacy Consultant will continue to monitor medication carts and rooms for expired meds on a monthly basis. **Date of Correction** Compliance will be met by 12/19/17 and on an ongoing basis.	12/19/17

Hawaii Dept. of Health, Office of Health Care Assuranc

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4 213	11-94.1-54(d) Sanitation (d) Every facility shall maintain an effective pest control program so that the facility is free of pests and rodents. This Statute is not met as evidenced by: Based on observation, interview with resident and staff members and review of the facility's invoices and e-mails, the facility failed to ensure the maintenance of an effective pest control program. Findings include: On 10/23/17 at 1:27 P.M. while standing in the hallway outside of Room 148, a staff member was observed to stomp his foot on the ground, kick something on the ground toward the bathroom and began talking to the Resident #287. The staff member then walked over and picked something off the floor with a paper towel. The staff member was heard informing the resident that he killed a cockroach. Subsequently an interview was done with Resident #287. The resident replied negatively regarding cockroaches; however, reported there are a lot of lizards on the ceiling above her and has concerns that they may fall on her while she is lying in bed. Throughout the survey (10/23/17 through 10/26/17) ants were observed to be crawling on the conference room table. On 10/26/17 at 11:55 A.M. an interview and walk through the facility was done with Staff Member #365. The staff member reported the facility has a contract for pest control. The contractor will come in quarterly for maintenance; however, Staff Member #365 does not keep track/log of when the contractor provides quarterly maintenance.	4 213	**4 213 Sanitation** **Corrective Action** This facility will ensure that it maintains an effective pest control program for residents, staff and the public. Entire facility was treated by pest control company, Accu-Pest, on 11/13/17. Monthly facility treatment was completed on 12/7/17. Quarterly treatment completed on 12/14/17. Email education sent on 11/30/17 to inform Maintenance if any pests are spotted for immediate treatment of area. No residents were identified to have been affected by this deficiency. All residents have the potential to be affected by this deficiency. **Responsible Person** The Maintenance Director will be responsible for on-going compliance and safety.	

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4 213	Continued From page 13 Staff Member #365 also reported the facility will call their contractor if there are concerns. The staff member stated he was not aware of lizards in the facility. The staff member was agreeable to review and provide invoices and e-mails that document that quarterly maintenance (pest control) services were provided by the contractor. On 10/26/17 at approximately 12:30 P.M. Staff Member #365 provided invoices documenting the following: quarterly pest control and rodent control on 9/12/17; rodent control trapping on West Wing Nursing Station on 1/4/17; rodent control trapping, day health on 1/4/17; and quarterly pest control and quarterly rodent control on 12/8/16. A review of the e-mails provided found services were provided on the following dates: 9/26/17 (Pikake Unit, Room 103 ants in room on the floors and walls); and 10/6/17 (Ilima Unit, large black ants on clerk and nurse desk area as well as on wall and floor). An e-mail dated 9/7/17 from the contractor notes the need to schedule the following pest control services: quarterly pest control in/out on 9/12/17 and kitchen monthly pest control on 9/12/17. There is no documentation of quarterly pest control services by the contractor from 12/8/16 through 9/12/17. The facility failed to ensure an effective pest control program was maintained as evidenced by no documentation of quarterly and annual pest control services from the facility's contractor.	4 213	**Systemic Changes and Monitoring** Maintenance Director will ensure to have available service log/records of all pest treatments by contracted vendor. Maintenance Director will conduct daily audits on pest control issues for the next 4 weeks then weekly for the next 2 months. Then monthly thereafter. Any and all issues will be repaired immediately and reported to daily stand up meeting as well as discussed monthly at Quality Assurance Performance Improvement Committee (QAPI) meetings. **Date of Correction** Compliance will be met by 12/19/17 and on an ongoing basis.	12/19/17