AMENDED

PRINTED: 11/08/2017
FORM APPROVED

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
AMENDED POC	125042	A. BUILDING: _____ B. WING _____	10/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAHU CARE FACILITY	1808 SOUTH BERETANIA STREET HONOLULU, HI 96826

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	11-94.1 Initial Comments A re-licensing survey was completed on 10/06/2017. At the entrance conference there were 75 residents in this 82 bed facility.	4 000		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to treat five residents (Residents #16, #130, #56, #58, and #21) with respect and dignity. Findings include: 1) While observing a staff member during medication administration on 10/5/17 at 8:30 A.M., Surveyor observed another staff member (Staff #103) handling two residents (Resident #16 and #130) in a rough manner. After the breakfast meal, Resident #16 was seated in her wheelchair at the dining table with her head tilted forward. Staff #103 came along	4 115		

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Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Layle E. Rodrigues — TITLE: Director of Nursing — (X6) DATE: 11/24/17

STATE FORM 6899 3KOW11 If continuation sheet 1 of 17

C: 12-22-17 to SS; PS

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4 115	Continued From page 1 and without first speaking to the resident, she abruptly and in a rough manner pushed Resident #16's head upright. Resident #16 did not show a reaction to Staff #103's rough touch. In a rough and abrupt manner, Staff #103 then roughly placed Resident #16's left hand onto her lap followed by her right hand in the same rough and abrupt manner. Staff #103 then took a newspaper and roughly placed it onto Resident #16's stomach then grabbed the resident's left hand in a rough manner and placed the resident's hand onto the newspaper. Both of Resident #16's hands slipped off her lap and Staff #103 was again observed grabbing both hands in a rough manner and again abruptly and roughly putting the resident's hands on her lap. Resident #16 did not show a reaction to Staff #103's rough handling. During this time, Staff #103 appeared agitated: not smiling, appeared rushed and seemed annoyed at Resident #16 (Staff #103 appeared to be speaking to the resident during the rough handling but Surveyor couldn't hear from across the room). Staff #103 left Resident #16 in her wheelchair sitting sideways in relation to the table then tended to Resident #130. Again, Staff #103 was observed to abruptly and roughly grab onto Resident #130's left hand then right hand and roughly placed her hands onto the table while she pushed her wheelchair towards the table. Staff #103 went to the kitchenette area to get a paper placemat. She returned with the placemat and roughly placed the placemat onto the table in front of Resident #130. Staff #103 then got Resident #130's breakfast tray and roughly placed the dishes in front of the resident. During the interaction with Resident #130, Staff #103 appeared agitated - no smiling, no gentle talking, agitated look on her face. Staff #103 continuously looked over at the Surveyor and	4 115		

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4 115	Continued From page 2 appeared to be aware that she was being observed. During all of these interactions, another staff member (Staff #121) was seated nearby feeding another resident. Staff #121 continuously looked over at the Surveyor while the Surveyor watched Staff #103. An interview of Resident #16 on the afternoon of 10/5/17 at 1:25 P.M. revealed she didn't feel afraid of Staff #103. Resident #16 was asked if Staff #103 treats her in a rough manner to which she replied, "Yes, sometimes she's rough." On the morning of 10/6/17, a medical record review found Resident #16 was admitted to the facility on 7/12/17 with diagnoses which included non-Alzheimer's Dementia; Neurogenic bladder; and Dysphasia. According to Resident #16's medical record, she was alert and oriented x 1 to 2. A review Resident #16's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/19/17 noted under Section G Functional Status, requires extensive assistance with one person physical assistance with: Transfer; Dressing; Toilet use; Personal hygiene. Resident #16 is totally dependent with one person physical assistance with: Locomotion on unit; Locomotion off the unit; and Bathing. Resident #130 was not interviewable. She was admitted to the facility on 8/22/17 with diagnoses which included history of hip fracture, dementia, and hypertension. On the morning of 10/6/17, a review of Resident #130's medical record found an MDS with ARD of 8/29/17 which noted the resident had short and long term memory problems. Additionally, Resident #130 required: Extensive assistance with 2 person assistance for transfer; Totally dependent with one person physical assistance with locomotion on and off	4 115		

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4 115	Continued From page 3 the unit, dressing, toileting, personal hygiene and bathing. An interview of Staff #121 on the afternoon of 10/5/17 at 1:00 P.M. was conducted to determine whether her observations of Staff #103 treating the residents roughly earlier in the day were typical of Staff #103. Staff #121 reported, "Sometimes it's like that because maybe she had other residents to care for in the room." Staff #121 reported that it can sometimes feel like a lot of assignment for staff, particularly when they have several dependent residents. An interview of Staff #103 on the afternoon of 10/5/17 at 1:03 P.M. found her stating, "I love my residents." Staff #103 reported she frequently received training on abuse/neglect - at least every month. Surveyor asked Staff #103 if she gets frustrated when working with residents who require extensive assistance with Activities of Daily Living (ADLs). Staff #103 answered, "It's our job." Staff #103 stated that Resident #130 can sometimes do things for herself but cooperation is dependent on her mood. Staff #103 stated Resident #130 often drops her body and she therefore has to assist her with her posture. Staff #103 stated Resident #130 became more alert since lunch and was doing more for herself in comparison to the morning when she was totally dependent. Staff #103 reported that Resident #16's head sometimes goes all the way down and has to "straighten" her head. She noted that sometimes Resident #16 falls asleep and her head drops and Staff #103 then has to push her head up. An interview of the Nursing Supervisor on the afternoon of 10/5/17 at 1:23 P.M. revealed that as far as she knew, no one has ever complained	4 115		

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4 115	Continued From page 4 about Staff #103. She added that she never had any concerns of abuse/neglect with Staff #103. However, the Nursing Supervisor was new to the facility, having been there only a few months prior to survey. An interview of Staff #54 on the afternoon of 10/5/17 at 1:36 P.M. revealed she had not been working in patient care over the past 2 years but when she did, she worked with Staff #103. When asked about her experience with Staff #103, Staff #54 recollected that Staff #103 had a complaint about her rough tone of voice. She recalls that the nursing supervisor previously had to verbally counsel her about her rough tone of voice. The Surveyor informed Staff #54 of her observations of Staff #103 on the morning of 10/5/17. Staff #54 responded that it sounded "excessive" and that she had never observed her being "that rough" with the residents. An interview of the Administrator on the morning of 10/6/17 at 7:10 A.M. revealed she did not have concerns about Staff #103. She reported that in the past, Staff #103 only had to be reminded of speaking loudly in the hallway. Aside from that incident, the Administrator did not have any further concerns. A review of Staff #103's personnel file on the morning of 10/6/17 revealed she had been employed at the facility since 5/7/01. Staff #103's personnel file contained multiple incidents resulting in disciplinary action. The following incidents were of concern: 3/4/03 - Staff #103 was verbally warned: Staff #103 insisted a resident brush her teeth while seated on the toilet despite the resident's refusal. Staff #103 had the resident use a portable basin where she had the resident brush her teeth, rinse	4 115		

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4 115	Continued From page 5 her mouth and spit. Staff #103 placed the resident's toothbrush on the floor of the sink then had the resident spread her legs while on the toilet and emptied the basin into the toilet. 6/29/04 - Staff #103 was suspended for 3 days: Staff #103 was assigned to showers when a resident's family members asked that the resident get showered and her hair washed before leaving on a family outing. Upon the family's arrival, Staff #103 was observed by several witnesses as being loud and argumentative with the resident's family members regarding their request. Staff #103 finally showered and washed the resident's hair. The resident reported that Staff #103 was verbally abusive during the entire bathing process. The resident was visibly upset and canceled her family outing. Along with being suspended, Staff #103 was required to attend a counseling session at the Employee Assistance Program (EAP). 7/9/04 - Staff #103 received her second written warning in a month regarding not staying for mandatory overtime. 1/2/09 - Staff #103 was verbally warned: Staff #103 and another staff member got into a verbal conflict in the hallway where they were both observed yelling at each other, calling each other names and sticking finger at each other. The Charge Nurse had to intervene to break up the altercation. 1/3/13 - Staff #103 was suspended for 5 days: During morning rounds on 12/3/12 the Director of Nursing (DON) found a resident sitting on a shower chair over the toilet with a gait belt around her abdomen/chest and the gait belt strap attached to the pipe over the toilet. The resident was calm and pleasant; nodding in response to the DON's questions but was unable to follow any directions. The DON found a Registered Nurse (RN) and another Certified Nurses Aide (CNA) to	4 115		

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4 115	Continued From page 6 assist the resident while the DON searched for Staff #103. The resident had a bowel movement so she was cleaned, dressed and placed into her wheelchair by the other staff who was not assigned to the resident. The resident was smiling and pleasant during all interaction with her communication limited to nodding her head in response to questions. The resident had no visible reaction to the gait belt placement and was unaffected by her positioning. The DON finally located Staff #103 and the Charge Nurse on break in the staff lounge. Staff #103 acknowledged she placed the gait belt around the resident "for her safety". Staff #103's primary concern was since the resident leans forward while on the toilet, she feared the resident would fall. Staff #103 reported that as she brought the resident to the toilet, another staff member came along to inform Staff #103 that her break time was switched and she'd have to take her break at that time. Staff #103 relented to the switch but said before she left the floor she informed the floor Charge Nurse she would go on break and that the resident was still on the toilet. However, the Charge Nurse understood from their verbal exchange only that the resident did not have a bowel movement. The Charge Nurse was unaware the resident was still on the toilet at the time, trying to "make". The facility failed to treat two residents (Residents #16 and #130) with respect and dignity. Staff #103 had a history of being volatile and unable to control her emotional reactions to situations and persons. Although both residents did not experience harm during the survey observations, Staff #103 appeared agitated and treated both residents in a rough manner.	4 115	4 115.1 Staff #103 was counseled and received extensive training on the principles of care, resident rights, abuse and neglect, communication skills, and resident preferences. Mandatory inservice was given to staff on Resident Rights and the proper principles of care. Nursing Supervisors make daily rounds to see the residents and ensure the staff are practicing the principles of care appropriately. Staff have been trained to identify any potential risks, observe and identify any deficient practice of inappropriate treatment of residents, and take immediate action to remedy the situation. The Director of Nurses and/or designee will report the results of any cases reviewed at the Quarterly Quality Improvement Committee Meeting.	10/6/17 10/9/17 and ongoing 10/9/17 and ongoing 10/9/17 and ongoing ongoing

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4 115	Continued From page 7 2) During a staff interview on the morning of 10/3/17 at 9:07 A.M., the Nursing Supervisor walked down the hall calling out to one of the Licensed Nurse's, "[Staff Name] does [Resident #56] have a sore?" She called out that question three times while trying to track the Licensed Nurse. Several residents were out in the hallway and several were in their rooms. The Nursing Supervisor called out loud enough for the residents and other staff to hear her. The facility failed to maintain Resident #56's dignity by loudly announcing information about her medical condition. 3) Resident #21 was admitted on 6/16/16 with MS, (Multiple Sclerosis), Hypertension, Congestive Heart failure, Kidney disease and Depression. During the resident interview on 10/02/17 at 9:15 AM, Resident #21 was observed with bilateral upper and lower extremity contractures which he stated confines him to his bed. At 11:00 AM Resident #21 was observed to be wheeled in his bed to the activity room wearing his hospital gown. On 10/04/17 at 1:30 PM Resident #21 was observed to be wearing his hospital gown while in his room. During an interview with the resident on 10/06/2017 10:47 AM in the activity room, Resident #21 stated that he was participating in another resident's birthday party, he was wearing a hospital gown. During an interview on 10/06/17 at 11:42 AM staff #64 stated that Resident #21 is very stiff which	4 115	4 115.2 Staff were inserviced on the need for resident privacy and dignity by using prudent conversations. Staff are not to communicate with each other regarding confidential resident information within hearing distance from other residents and/or visitors. Nursing Supervisors make daily rounds observe staff interaction, see the residents and identify any privacy and dignity issues. Staff education regarding resident dignity and respect will continue during orientation, annual and at monthly staff meetings. The Director of Nurses and/or designee will report any deficiencies identified regarding resident dignity and respect at the Quarterly Quality Improvement Committee Meeting. 4 115.3 Resident #21 was asked what type of clothing he preferred. (4) new shirts were purchased on his behalf so he will be appropriately dressed in the common areas. An audit was conducted and no other resident was identified as not having sufficient street clothing to be properly dressed while out of their room. Audits by the Director of Nurses and/or designee of residents not wearing street clothing out of their room will be	10/9/17 10/9/17 and ongoing 10/9/17 and ongoing ongoing 10/9/17 10/9/17 10/9/17 and ongoing

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4 115	Continued From page 8 makes it difficult to put a t-shirt on. Staff #64 suggested getting a very large shirt or cut the shirt to make the back open may be easier. It would be better for the resident to wear a shirt instead of his hospital gown when he goes to activities. Review of the "Out of the room activities plan" on 10/05/17 states, "Resident is to be taken out of the room in his bed daily except Sundays". Review of the MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 6/08/17 revealed as personal preferences that it is very important to choose what clothes to wear. Review of the quarterly resident care conference report dated 6/20/17, Resident #21 stated he would like the facility to buy a shirt instead of wearing a hospital gown. The facility failed to assist the resident to dress in clothes appropriate to the time of day and individual preferences enhancing his quality of life. 4) On 10/03/2017 at 8:55 AM during Stage 1 of the survey, went to R#58's room to complete observations and a sign was posted above the resident's side table, "Does (Mrs. surname) have her teeth on? The resident was in a room with three other residents separated by privacy curtains and the sign could be viewed from the foot of the bed where staff and visitors passed through the room. On 10/06/2017 at 7:55 AM interviewed Staff#74 and she was shown the sign posted in R#58's room. According to Staff#74, R#58 often takes dentures off and places in napkin and lost dentures 3-4 months ago. Staff#74 was not sure whether staff or resident's daughter put sign up	4 115	conducted weekly X 3, monthly X 3, and quarterly thereafter. The Director of Nurses and/or designee will report the results of the audits at the Quarterly Quality Improvement Committee Meeting [QQICM] 4 115.4 It was noted that the resident's family placed the sign on the bedside table. It was explained to the family that signs are appropriate but due to dignity and privacy, they must be placed either in the resident's closet or covered with a privacy sheet so other residents and/or visitors are not able to see the message. Staff were inserviced on signs being posted at the bedside and the need to maintain the residents' dignity by placing any signage regarding their care, in the resident's closet or covered with a privacy sheet. During an audit to identify any and all signage in resident rooms that may violate their dignity and respect, none were found. Audits will be conducted by the Director of Nurses and/or designee of residents who have any signs posted in their rooms that would be a dignity/privacy issue, weekly x 3, monthly x 3, quarterly thereafter. The Director of Nurses and/or designee will report the results of the audits at the Quarterly Quality [QQICM]	ongoing 10/9/17 10/12/17 10/9/17 10/9/17 and ongoing ongoing

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4 115	Continued From page 9 but would find out and educate staff and/or family about dignity issue. The facility did not protect the dignity of R#58 by posting confidential information at the bedside regarding denture use.	4 115	4 130 The criminal background check was provided for staff #103 for date of hire 5/7/01. Human Resource staff had to go to Hawaii Criminal Justice Center to manually perform a criminal background and then manually document their findings. The list of criminal background checks provided was completed on 5/2/01 and not 5/2/17. All names on the list were all checked as indicated on the results as no conviction. Criminal check documentation generated on 4/28/17 is for our annual criminal background checks for current staff which was conducted on 5/5/17. This information was provided during the survey.	10/9/17
4 130	11-94.1-29(a) Resident abuse, neglect, and misappropriation (a) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Statute is not met as evidenced by: Based on observations, interviews and personnel record reviews, the facility did not implement written policies and procedures for conducting pre-employment criminal background checks. Findings include: On the morning of 10/5/17 at 8:30 A.M., Staff #103 was observed treating 2 residents (Residents #16 and #130) in a rough manner warranting a review of her personnel file. On the morning of 10/6/17 at 10:00 A.M. a review of Staff #103's personnel file revealed the facility did not obtain a criminal background check prior to hiring her on 5/7/01. On the morning of 10/6/17, the Administrator provided a criminal background check for Staff #103 which was dated 4/28/17. The Administrator explained the	4 130	Nursing Supervisors make daily rounds to see the residents and ensure the staff are practicing the principles of care appropriately. New hires must complete a criminal background check, fingerprinting and complete orientation which includes Resident Abuse and Neglect, and Resident Rights training. Staff have been trained to identify any potential risks, observe and identify any deficient practice of inappropriate treatment of residents, and take immediate action to remedy the situation. The Director of Nurses and/or designee will report the results of any cases reviewed at the Quarterly Quality Improvement Committee Meeting.	10/12/17 10/9/17 and ongoing 10/9/17 and ongoing ongoing

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4 130	Continued From page 10 background check went back 10 years, taking it back to 2007. Surveyor asked for the background check before Staff #103's hire date of 5/7/01. The Administrator provided a list created by the facility (rather than a printed version from the agency providing the criminal background checks) of staff members who received a criminal background check on 5/2/07. The column which read, "Date Record Check Completed", noted "5/2/17" with a line drawn down the rows of employees' names and stopped at the name right above the row for Staff #103, indicating it was not done. The facility failed to provide the necessary pre-employment criminal background check for Staff #103.	4 130		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's	4 149		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAHU CARE FACILITY	1808 SOUTH BERETANIA STREET HONOLULU, HI 96826

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4 149	Continued From page 11 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, staff and resident interviews and record review the facility failed to do a comprehensive nursing assessment and include resident (R)#21's hearing deficit into an overall plan of care for ongoing evaluation and monitoring. Findings: 1) On 10/02/17 at 10:01 AM during the resident interview Resident #21 had difficulty hearing the questions that were being asked. In order for the resident to hear the question. The surveyor moved close to the resident's right ear and spoke in a louder voice. Resident #21 stated that he started having trouble hearing in his right ear 2 months ago and was waiting for a hearing test. On 10/04/17 at 10:05 AM the television could be heard at a high volume from the hallway outside the resident's room. Upon entering the room, Resident #21 was laying in bed awake watching a television program. At 11:45 AM during personal care being given to the resident by the CNA, the CNA was observed to lean to the resident's right ear and speak louder to the resident in order for the resident to hear the questions asked by the CNA. The resident stated to the CNA that he has been having a hard time hearing in the right ear, concurring with the resident's initial report to the surveyor on 10/02/17 about having a difficult time hearing in the right ear.	4 149	4 149 The resident is bed-bound. Staff has tried to schedule an audiologist appointment however, the (4) audiologist contacted could not accommodate a gurney. This information was not documented in the resident's record. Subsequent to the survey, an audiologist was found to accommodate a resident on a gurney. The appointment is scheduled for December 5, 2017. A modification of the comprehensive and quarterly Minimum Data Set (MDS) assessments with Assessment Reference Dates of 6/8/17 and 9/7/17 respectively were completed to reflect a hearing deficit based on observation and staff and resident interviews. Staff were inserviced on Resident Rights and need to perform a comprehensive assessment on all residents, to including hearing deficits and to follow-through on physician orders and/or referrals. An audit was conducted to identify any other resident who may have a hearing deficit and if they physician ordered any consultative services. There were none identified. Audits will be conducted by the Director of Nurses and/or designee of residents' hearing deficient and follow-through on referrals and other consultative services, weekly x 3, monthly x 3, and quarterly thereafter.	10/12/17 11/15/17 10/12/17 and ongoing 10/9/17 10/9/17 and ongoing

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4 149	Continued From page 12 Review of the medical records on 10/06/17 revealed a lack of documentation of hearing loss and/or follow up for a hearing evaluation. Review of the Minimum Data Set (MDS) quarterly review with Assessment Reference Date of 9/07/17 Section B hearing, speech, and vision, Hearing code is 0 indicating resident's hearing is adequate, no difficulty in normal conversation, social interaction, listening to TV. Review of the resident's Care Plan dated 6/15/17 does not include goals or interventions for hearing/communication. Review of the quarterly resident care conference report dated 6/20/17 revealed documentation that the resident is concerned about not being able to hear in the right ear. Review of the Physician note dated 9/20/17 states "Persistent hearing loss. Assessment and plan: Hearing loss, audiology eval, cerumen impaction, debrox". Prior to the 9/20/17 Physician note there is no documentation about hearing loss for the resident. The progress notes from 8/26/17 to 9/30/17 were reviewed. A Social Services progress note dated 9/09/17 states resident is hard of hearing. No other documentation in the progress notes indicate Resident is having difficulty with hearing or that there is any follow up being done to obtain a radiological evaluation. Review of the Physician orders dated 9/20/17 revealed orders for Debrox 5 drops to left ear TID for 3 days and an Audiologist referral. During an interview on 10/06/17 at 11:28 AM, staff #64 reported that the facility made an effort to schedule an audiology evaluation for Resident #21 and had not been able to find an Audiologist who can take the resident on a gurney, explaining that the resident can't go in a geri or wheelchair because of the inability to bend the lower	4 149	The Director of Nurses and/or designee will report the results of the audit at the Quarterly Quality Improvement Committee Meeting	ongoing

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4 149	Continued From page 13 extremities. Staff #64 added that the resident hasn't complained about the hearing loss in a few weeks so the Physician probably forgot about the referral for the audiology evaluation. Staff # 5 concurred with staff #64 that the facility looked for and was not able to find an Audiologist who can accommodate the resident on a gurney.	4 149		
4 177	11-94.1-44(a) Specialized rehabiiltation services (a) The facility shall provide for specialized and supportive rehabilitation services, including occupational therapy, physical therapy, and speech therapy, according to the needs of each resident, either directly by qualified staff or through arrangements with qualified outside resources. Services shall be programmed to: (1) Preserve and improve the resident's maximal abilities for independent function; (2) Prevent, insofar as possible, irreversible or progressive disabilities; and (3) Provide for the procurement and maintenance of assistive devices as needed by the resident to adapt and function within the resident's environment. This Statute is not met as evidenced by: Based on observations, medical record review (MRR) and staff interviews the facility failed to ensure that 1 of 5 residents (R#35) observed with contractures and no splint device was provided appropriate treatment and services to prevent further decrease in range of motion. Findings include:	4 177	4 177 The Nursing Supervisor audited resident #35's record and found the rehab department's recommendation to discontinue the splint on 4/11/17, due to the resident's functional left upper extremity and the resident did not need the left hand splint. This was not documented at the time of the recommendation. The Care Plan was revised and the Splint Schedule discontinued. Staff were inserviced on the need to continue evaluating residents' need for splinting and other rehabilitative measures, and if the recommendation is to discontinue, obtain a physician order, and revise the Care Plan. An audit was conducted to identify all residents who have splints to ensure they still need to be on a splinting schedule. There were no changes as the residents continue to require splinting. Audits will be conducted by the Director of Nurses and/or designee of residents with splints to ensure the continue need for preventative care, weekly x 3, monthly x 3, and quarterly thereafter. The Director of Nurses and/or designee will report the results of the audit at the Quarterly Quality Improvement Committee Meeting.	10/9/17 10/12/17 10/9/17 10/9/17 and ongoing ongoing

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4 177	Continued From page 14 On 10/03/2017 at 08:34 AM, R#35 was observed in the facility's activity/dining room and his bilateral hands were in a fist position on his lap. On 10/06/2017 at 8:01 AM observed R#35 being fed breakfast in the activity/dining room. Queried the CNA feeding him if the resident's hands were contracted and unable to hold a spoon. The CNA demonstrated that R#35 was able to open his hands but had tendency to contract fingers. The MRR on R#35 included care plan (CP))#2, "Assistance required in performing ADLs r/t Parkinson's disease, and dementia dated 8/21/17. The interventions included: total assistance with eating; ambulation limited asst; device used FWW CGA with gait belt... The MRR also found that R#35 had an, "Occupational Therapy Upper Extremity Splint Schedule," with directions to apply to the left hand splint while in bed from 10 PM - 7 AM. The CNA training was signed on 05/28/15. The form "Resident's Care Planned Activity Level," updated 3/10/17, included under the special instructions box," 6. L hand splint on at night 10 PM - 7 AM." The residents annual minimum data set (MDS) 3.0 with assessment review date (ARD) of 08/02/2017 included that services for occupational therapy started on 12/02/2016 and ended on 01/05/2017. On 10/06/2017 at 8:29 AM asked the CNA in R#35's room to help locate the resident's splint. The CNA was unable to find any splints for the resident and stated that the left hand splint was discontinued to her knowledge.	4 177		

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4 177	Continued From page 15 On 10/06/2017 at 8:49 AM interviewed Staff#49 and queried whether splint device for R#35 still being used or discontinued because in the MRR found splint device schedule and picture of how splint should be applied. Staff#49 was recently employed by the facility and had to ask CNA staff but they didn't know whether splint was discontinued and when the therapy staff were asked they didn't have old record on R#35's use of splint. The facility failed to provide adequate preventive care for further decrease in ROM for R#35.	4 177		
4 278	11-94.1-65(e)(5) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (5) Multi-resident bedrooms shall provide a minimum of eighty square feet per bed of usable space, excluding closets, bathrooms, alcoves, and entryways; This Statute is not met as evidenced by: Based on observations, staff interviews and room measurements, the facility did not provide a minimum of eighty square feet per bed of usable space for the multi-resident bedrooms. Findings include: On 10/05/2017 at 8:44 AM interviewed Staff# 3 and discussed multi-resident rooms should meet requirements of 80 sq ft of usable space /per resident and there were four residents to a room.	4 278		

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4 278	Continued From page 16 Accompanied Staff#3 and Staff#12 to room 312. Staff#12 measured the room and excluded egresses (closets, and space for wheelchair storage, side tables for TV, etc.) and room measurements were 27 x 10.5 ft which equaled to 71 sq. ft /per resident. On 10/06/2017 at 6:32 AM interviewed Staff#3 and she spoke with the facilities owner on whether there was a room waiver request in the past. According to the owner the facility will be requesting room waivers as there were 10 multi-resident bedrooms on each of the 2 floors with the same measurments of 71 sq ft/per resident. The facility did not provide adequate living space in the multi-resident bedrooms to ensure the health and safety of residents.	4 278	4 278 The facility has requested a waiver to the construction requirements.	11/16/17