Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Lunalilo Home	**CHAPTER 100.1**
Address: **501 Kekauluohi Street, Honolulu, Hawaii 96825**	**Inspection Date: February 17-19, 2016 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – "Vitamin D3 5,000 unit capsule take two capsules by mouth once every day" ordered 12/28/15; label reflected take "one capsule;" the medication record reflected "two capsules." Resident #3 – "Levetiracetan 100 mg/ml solution take 5 ml by mouth every twelve hours" ordered 1/16/16; the medication record reflected the medication is given 0600 (6 a.m.) and 1700 (5 p.m.). Resident #4 – "Bethanechol 25 mg tab take one tab by mouth three times per day. Take on an empty stomach 1 hour before or 2 hours after a meal." The medication record noted 1600 (4 p.m.); however, dinner is served at 4:15 p.m.	Resident #1: The deficiency was immediately corrected by changing the error of "one capsule" to "two capsules" on the medication bottle which now matched what was correctly reflected on the MAR.	02/22/2016
		To prevent this deficiency from recurring, an in-service to all licensed staff was provided to review the deficiency and to remind the licensed staff that all new orders are double checked by two (licensed staff) to ensure the order was completely/correctly transcribed and processed.	04/14/2016
		#1. Medication Policy updated to reflect that all changes in orders are transcribed by a licensed nurse and co-signed by a second licensed staff. The licensed staff are responsible for the proper transcription to the Medication Administration Record, and label. The Director of Nursing (DON) will oversee for compliance.	06/27/2016
		Resident #3: The deficiency was immediately corrected by changing the time in the MAR from 1700 to 1800 thus reflecting 0600-1800 administration.	02/22/2016
		To prevent this deficiency from recurring, an in-service to all licensed staff was provided to review the deficiency and to reiterate the importance of transcribing the order as written, not based on when the other medications are given.	04/14/2016
		#3. Medication Policy was updated to reflect that medication is to be made available to the resident as ordered by the physician specific to time given. Transcription of all orders by a licensed nurse and co-signed by a second licensed staff is required. The Medication Policy also reflects the specific meals times which are: Breakfast - 0730, Lunch - 1200, and Dinner -1630. The licensed staff are responsible for the proper transcription of all orders and the DON will oversee for compliance.	06/27/2016

	Rules (Criteria)	Plan of Correction	Completion Date
	Resident #4 – Medication label reflected "Alendronate sodium 70 mg tab take one tablet by mouth weekly with water 30 minutes before first food, drink, med. Avoid lying down for 30 minutes after." The medication record reflected alendronate sodium is given with "finasteride, metoprolol, Namenda, bethanechol, multivitamin and omeprazole. Resident #4 – "Acetaminophen (Tylenol) 325 mg tabs take 2 tabs by mouth every 4 hours as needed for pain or fever" ordered 2/11/16, 1/26/16, 12/3/15; "500 mg tablets" available.	Resident #4: The deficiency was immediately corrected by changing the times of administration in the MAR based on our meal times; 0730 - brkfst, 1230-lunch, and 1630-dinner. The corrected administration times are: 0630, 1430, and 1830.	02/22/2016
		To prevent this deficiency from recurring, an in-service to all licensed staff was provided to review the deficiency and to reiterate the importance of transcribing the order as written and highlight in the MAR any special instruction.	04/14/2016
		#4. Medication Policy was updated to reflect that medication is to be made available to the resident as ordered by the physician specific to time given. Physician orders are transcribed by a licensed nurse and co-signed by a second licensed staff. The licensed staff are responsible for proper transcription of the order and the DON will oversee for compliance.	06/27/2016
		Resident #4: The deficiency was immediately corrected by changing the time of administration in the MAR to 0600, which is 30 minutes before first medication. To prevent this deficiency from recurring, an in –service to all licensed staff was provided to review the deficiency and to reiterate the importance of transcribing the order as written and to highlight the specific instructions in the MAR.	02/22/2016 04/14/2016
		#4. The Medication Policy was updated to reflect the need that medication is to be made available to the resident as ordered by the physician, specific to time given. Transcription of each physician order is noted by a licensed staff and co-signed by a second licensed staff. The licensed staff are responsible for the proper transcription of orders and the DON will oversee for compliance.	06/27/2016
		Resident #4: The deficiency was immediately corrected by discarding the Acetaminophen -500 mg tablets and replacing them with Acetaminophen-325mg tabs. To prevent this deficiency from recurring, an in-service to all licensed staff was provided to review the deficiency and to reiterate the importance of ensuring the proper medication with correct dose are checked when received against the MAR to prevent any error in dose. Staff also instructed to highlight the specific instructions in the MAR.	02/22/2016 04/14/2016
		#4. The Medication Policy was updated to reflect the need that the correct dosage of medication is to be made available to the resident as ordered by the physician. Each physician order is transcribed by a licensed staff, and co-signed by second licensed staff. The licensed staff are responsible for the proper transcription of orders and the DON will oversee for compliance.	06/27/2016

☒	§11-100.1-15 Medications. (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year. **FINDINGS** Resident #1 – No documentation that medication was reevaluated prior to 12/28/15. The resident was admitted 8/23/13.	Resident #1: This deficiency is unable to be corrected. To prevent this deficiency from recurring, a new section was added to the Monthly Progress Summary form that asks the writer to verify if the physician orders were reevaluated and signed by the physician/APRN within a four month period. An in-service to all licensed staff was provided to review the deficiency and the correction.	02/22/2016 04/14/2016
		#1. To prevent similar deficiencies from reoccurring,the licensed staff completing the Monthly Nursing Summary are responsible to ensure that the medication orders are reevaluated and signed by the physician/APRN every four months or as ordered by the physician. Triggers have been added to the Monthly Nursing Summary and the Monthly Vital Signs form's. The Nursing Calendar is an additional tool to help trigger the need for an update. The Don will oversee for compliance.	06/27/2016
☒	§11-100.1-17 Records and reports. (a)(6) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Physician or APRN signed orders for diet, medications, and treatments; **FINDINGS** Resident #2 – No physician order for "HM Arthritis Pain ER 650 mg" and "HM Cal Antacid 500 mg" at the time of readmission on 9/16/15. Both medication were reflected on the September 2015 medication record (readmission).	Resident #2: This deficiency is unable to be corrected. There were no admission orders for both items. They were reinstated in error during the readmission process and eventually discontinued. None were ever given. To prevent this deficiency from recurring, an in-service for review of the deficiency and for discussion was completed w/all licensed staff. The importance of the 2nd licensed staff verification of transcription was emphasized.	02/22/2016 04/14/2016
		#2. The Medication Policy was updated to reflect the need that there is a physician order for all medications specific to: admission, re-admission, and/or transfer. Each physician order is transcribed by a licensed staff, and co-signed by a second licensed staff. The licensed staff are responsible for the proper transcription of orders and the DON will oversee for compliance.	06/27/2016

☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; **FINDINGS** Resident #1 – Progress notes did not reflect resident sleep pattern related to diagnosis of "sun downing" and "insomnia." Resident #1 – Progress notes did not reflect "rash" to resident's "back, left arm and inner thighs" that was noted on the case manager's notes of 11/6/15.	Resident #1: This deficiency was corrected by appropriate documentation in the Monthly Progress Summary for March that the resident was sleeping well and had no problems with sun downing or insomnia. To prevent this deficiency from recurring, an in-service to all licensed staff was provided to review the deficiency and note the corrected documentation in March. Additionally, the CM-Care Plan has been placed in the Monthly Progress Note Binder which will help w/better documentation and communication with CM.	03/01/2016 04/14/2016
		#1. To prevent similar deficiencies from recurring, the licensed staff/DON completing the Monthly Nursing Summary are responsible to ensure ongoing communication/documentation either by phone/visit with the Case Manager. The Monthly Nursing Summary Binder was created as a tool for the licensed staff/DON. This binder includes the CM-Care Plan, Current Diet List/LOC status, and Monthly Wt/Vital Signs List. The Monthly Summary Policy was updated to reflect the process and responsibility. The DON will oversee for compliance.	06/28/2016
		Resident #1: This deficiency was corrected by the Case Manager who added to the CM-Care Plan #5 –Skin. To prevent this deficiency from recurring, an in-service to all licensed staff was provided to review the deficiency and note the updated documentation in March. Additionally, the CM-Care Plan has been placed in the Monthly Progress Note Binder which will help w/better documentation and communication with CM.	04/02/2016 04/14/2016
		#1. To prevent similar deficiencies from recurring, the licensed staff/DON completing the Monthly Nursing Summary are responsible to ensure ongoing communication/documentation either by phone/visit with the Case Manager. The Monthly Nursing Summary Binder was created as a tool for the licensed staff/DON. This binder includes the CM-Care Plan, Current Diet List/LOC status, and Monthly Wt/Vital Signs List. The Monthly Summary Policy was updated to reflect the process and responsibility. The DON will oversee for compliance.	06/28/2016
		#1. The licensed staff/DON completing the Monthly Nursing Summary are responsible to ensure ongoing communication/documentation either by phone/visit with the Case Manager. The Monthly Nursing Summary Binder was created as a tool for the licensed staff/DON. This binder includes the CM-Care Plan,Current Diet List/LOC status, and Monthly Wt./Vital Signs List. The Monthly Summary Policy was updated to reflect the process and responsibility. The DON will oversee for compliance.	06/28/2016

☒	§11-100.1-84 Admission requirements. (a) Licensees of an expanded ARCH shall admit nursing facility level residents as determined and certified by the resident's physician or APRN. **FINDINGS** Resident #1 – No expanded adult residential care home (ARCH) certification when admitted as expanded ARCH on 3/2/15.	Resident #1: This deficiency is unable to be corrected. Certification points had been erroneously written in ARCH column vs. Expanded column. On 11/30/2015, Level of Care was updated and the certification points of 24 (expanded level) was placed in the correct column. To prevent this deficiency from recurring, an in-service to all licensed staff was provided to review the deficiency and note the corrected documentation of 11/30/15.	02/22/2016 04/14/2016
		#1. To prevent this deficiency (LOC points placed in wrong column), the Director of Admissions has a check-list used during the admission policy to verify the Level of Care/Certification form is completed correctly. The Director of Admissions is responsible to ensure proper level of care as certified by the physician or APRN. The DON will oversee for compliance.	06/28/2016
☒	§11-100.1-88 Case management qualifications and services. (c)(4) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions; **FINDINGS** Resident #1- The care plan updated on 2/4/16 did not include the following: 1. Physician order to crush medication 2. The resident requires total assistance with activities of daily living 3. Personal alarm ordered by the physician Resident #1 – No care plan for rash identified by the case manager on 11/6/15 with intervention (bath) and outcome (monitor). Resident #1 – No care plan for diagnosis of "sun downing" and "insomnia" noted on the case manager admission assessment that noted "monitor."	Resident #1: The three deficiencies noted (crushed medications; total assist with ADL's; personal alarm) were corrected by the Case Manager who added them to the CM-safety care plan. To prevent this deficiency from recurring, an in-service for all licensed staff was provided to review the deficiency and note the corrected documentation. Additionally, the CM-Care Plan has been placed in the Monthly Progress Note Binder which will help w/better documentation and communication with CM.	04/02/2016 04/14/2016
		#1. To prevent similar deficiencies from reoccurring, the licensed staff/DON completing the Monthly Nursing Summary are responsible to ensure ongoing communication/documentation either by phone/visit with the Case Manager. The Monthly Nursing Summary Binder was created as a tool for the licensed staff/DON. This binder includes the CM-Care Plan, current Diet List, Current LOC, and Monthly Wt's/Vttal Signs List. The Monthly Nursing Summary Policy was updated to reflect these changes. The DON will oversee for compliance.	06/28/2016
		Resident #1: The deficiency was corrected by the Case Manager who added the problem to the CM Care Plan #5 - Skin. To prevent this deficiency from recurring, an in-service to all licensed staff was provided to review the deficiency and note the corrected documentation. Additionally, the CM-Care Plan has been placed in the Monthly Progress Note Binder which will help w/better documentation and communication with CM.	04/02/2016 04/14/2016
		#1. As noted above #1, the licensed staff/DON completing the Monthly Nursing Summary are responsible to ensure ongoing communication/documentation either by phone/visit with the Case Manager. The Monthly Nursing Summary Binder was created as a tool for the licensed staff/DON. The Monthly Nursing Summary Policy was updated to reflect the above changes. The DON will oversee for compliance.	06/28/2016

☒	§11-100.1-88 Case management qualifications and services. (c)(4)		
	Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions; **FINDINGS** Resident #1- The care plan updated on 2/4/16 did not include the following: 1. Physician order to crush medication 2. The resident requires total assistance with activities of daily living 3. Personal alarm ordered by the physician Resident #1 – No care plan for rash identified by the case manager on 11/6/15 with intervention (bath) and outcome (monitor). Resident #1 – No care plan for diagnosis of "sun downing" and "insomnia" noted on the case manager admission assessment that noted "monitor."	Resident #1: According to the Case Manager: CM did monitor the issue by getting feedback/report from both family and staff and had noted at first visit following the admission, "patient is sleeping well, no problems with sun downing and/or insomnia." Although the patient had previous had problems in these areas, the problems did not continue and the RN/CM did not make an on-going care plan for these areas of prior concern. To prevent this deficiency from recurring, an in-service to all licensed staff was provided to review the deficiency and note the corrected documentation. Additionally, the CM-Care Plan has been placed in the Monthly Progress Note Binder which will help w/better documentation and communication with CM. #1. The licensed staff/DON are responsible to ensure ongoing communication/documentation either by phone/visit with the Case Manager. The Monthly Nursing Summary Binder is a tool to assist in the communicatinon process. The Monthly Nursing Summary Policy was updated. The DON will oversee for compliance.	04/02/2016 04/14/2016 06/28/2016

☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;	Resident #1: The deficiency was corrected on the March Progress Summary Note to reflect the current diet order. To prevent this deficiency from recurring, a licensed staff in-service for review/discussion of the issue was conducted. Additionally, placement of the most current Resident Diet List in the Monthly Progress Note Binder will help confirm and facilitate the most current diet order.	03/01/2016 04/14/2016
	FINDINGS Resident #1 – Progress notes from September 2015 to January 2015 stated resident is on "regular" diet and did not reflect the current diet order of "regular, mechanical soft/chopped" diet. Resident #2 – Progress notes did not include observations related to a significant weight loss of 8 lbs from November 2015 to December 2015. Resident #3 – Progress notes did not include observations on the resident's response to dysphagia pureed diet (ordered 1/16/16) and nectar thick liquids (ordered 1/16/16). Resident #4 – Progress notes did not include observations on the resident's response to fluid restrictions and Boost supplement.	#1. To prevent similar deficiencies from reoccurring, the licensed staff/DON completing the Monthly Nursing Summaries are responsible to ensure ongoing communication/documentation either by phone/visit with the Case Manager. The Monthly Nursing Summary Binder was created as a tool to be used for communication/documentation. The CM-Care Plan was removed from the Medical Chart and placed in the above binder. The Monthly Summary Policy was updated to reflect the above. The Dietary Manager is responsible for updating the Resident Dietary List. The DON will oversee for compliance.	06/28/2016
		Resident #2: The deficiency was corrected on the March Progress Summary Note to reflect a total weight loss from November – March, 2015 of 11 lbs. To prevent this deficiency from recurring in the future, the Monthly Vital Signs & Wt's form and Monthly Summary Progress forms were updated to reflect the following: Wt. loss of 5lbs or greater must be reported to the physician. This change was reviewed and discussed during a licensed staff in-service.	03/01/2016 04/14/2016
		#2. As noted above. The licensed staff/DON are responsible for completing the Monthly Nursing Summaries. The Monthly Nursing Summary Binder was created as a tool to assist with appropriate communication and documentation either by phone/visit with the Case Manager. The Monthly Summary Policy was updated to reflect the changes, Triggers were added to the Monthly Nursing Summary and the Monthly Wt./Vitals Signs form. The DON will oversee for compliance.	06/28/2016
		Resident #3: The deficiency was corrected by including on the March Progress Summary Note observations of the resident's response to dysphagia pureed and nectar thick liquids. To prevent recurrence, this finding was reviewed/discussed during a licensed staff in-service.	03/01/2016 04/14/2016
		#3. As noted above. The licensed staff/DON are responsible for completing the Monthly Nursing Summaries. The Monthly Nursing Summary Binder was created as a tool to assist with the appropriate communication and documentation either by phone/visit with the Case Manager. The Monthly Summary Policy was updated to reflect the changes. The DON will oversee for compliance.	06/28/2016
		Resident #4: The deficiency was corrected by including on the March Progress Summary Note observations of the resident's response to fluid restrictions and Boost supplement. To prevent recurrence, this finding was reviewed/discussed during a licensed staff in-service.	03/01/2016 04/14/2016

☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all		
	action taken. Documentation shall be completed immediately when any incident occurs; **FINDINGS** Resident #1 – Progress notes from September 2015 to January 2015 stated resident is on "regular" diet and did not reflect the current diet order of "regular, mechanical soft/chopped" diet. Resident #2 – Progress notes did not include observations related to a significant weight loss of 8 lbs from November 2015 to December 2015. Resident #3 – Progress notes did not include observations on the resident's response to dysphagia pureed diet (ordered 1/16/16) and nectar thick liquids (ordered 1/16/16). Resident #4 – Progress notes did not include observations on the resident's response to fluid restrictions and Boost supplement.	4	

11-100.1-17(b)(3). Resident #4. To prevent similar deficiencies from recurring, the licensed staff/DON completing the Monthly Nursing Summary Note are responsible to ensure ongoing/accurate communication either by phone/visit with the Case Manager. The Dietary Manager is responsible updating the Resident Diet List regarding fluid restriction and Boost Supplement. The Monthly Summary Binder is a tool developed to hold the most current information. The Monthly Nursing Summary Policy was updated to reflect the aforementioned process and responsibility. The Director of Nursing will oversee the above for compliance.

☒	§11-100.1-17 Records and reports. (b)(4) During residence, records shall include: Entries describing treatments and services rendered; **FINDINGS** Resident #1 – Weight parameter "Call RN CM if wt. loss of 75 lbs. from admission (91 lbs. monthly)" was not clarified with the physician. Resident #3 – No documentation that nectar thick liquids (ordered 1/16/16) was provided.	Resident #1: The deficiency was corrected by changing the Physicians Order Sheet to reflect the Case Managers Care Plan to notify CM of weight loss >5lbs. To prevent recurrence, the Monthly Vital Signs form and the Monthly Nursing Progress Summary, was changed to include a trigger by stating: Wt. Loss >5lbs, notify physician. Additionally, this information was included in the in-service for review/discussion with licensed staff as-well-as with the Dietary Manager. #1. To prevent similar deficiencies from reoccurring the licensed staff /DON completing the Nursing Monthly Summary are responsible for communicating any wt. loss of >5 lbs. to the physician and case manager. Triggers have been added to the Monthly Wt/Vital Sign form and Monthly Nursing form as a reminder to the licensed staff when this occurs. The Dietary Manager is responsible to monitor the weight of all residents on a monthly basis. The DON will oversee for compliance. Resident #3: The deficiency was corrected by including on the March Progress Summary Note documentation that nectar thick liquids was provided. To prevent recurrence, this information was included in the in-service for review/discussion with licensed staff as-well-as with the Dietary Manager. #3. The licensed staff/DON completing the Nursing Monthly Summary are responsible to ensure the information provided is accurate. The Nursing Summary Binder was created as a tool to help provide the most current information when communicating/documenting. The Dietary Manager is responsible for updating the Resident Dietary List. The DON will oversee for compliance.	04/02/2016 04/14/2016 06/28/2016 03/01/2016 04/14/2016 06/28/2016	

☒	§11-100.1-20 Resident health care standards. (c) The primary and substitute care giver shall be able to recognize, record, and report to the resident's physician or APRN significant changes in the resident's health status including, but not limited to, convulsions, fever, sudden weakness, persistent or recurring headaches, voice changes, coughing, shortness of breath, changes in behavior, swelling limbs, abnormal bleeding, or persistent or recurring pain. **FINDINGS** Resident #2 – No documentation that the physician was notified by the facility regarding a significant weight loss of 8 lbs from November 2015 to December 2015.	Resident #2: The deficiency was corrected by notifying the Physician, Case Manager, and Hospice of the resident's loss of weight between November 2015 to April 2015 of 11 lbs. To prevent recurrence, triggers have been placed in the Monthly Vital Signs/Wt. form and the Monthly Summary Progress Note forms regarding informing the physician of wt. loss >5lbs. This information was included in the licensed staff in-service for review/discussion. #2. To prevent similar deficiencies from reoccurring triggers have been added to the Monthly Wt/Vital Sign form and the Monthly Nursing Summary. The licensed staff/DON completing the Monthly Nursing Summary are responsible to ensure ongoing communications and documentation either by phone/visit with the physician and Case Manager regarding significant weight loss. The Dietary Manager is responsible to monitor the monthly weights. The DON will oversee for compliance.	04/13/2016 04/14/2016 06/28/2016

☒	§11-100.1-88 Case management qualifications and services. (c)(2) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident; **FINDINGS** Resident #1 and Resident #2 – Nutrition care plan did not include weight goal. Resident #1 and Resident #2 – Nutrition care plan did not address dehydration risk. Resident #2 – Care plan did not address dysphagia diagnosis and aspiration risk.	DUE TO THE LIMITED SPACE, THE POC FOR SECTION 11-100.1-88 BEGINS ON PAGE 6 AND CONTINUES ON PAGE 7: Resident #1/#2: The deficiency was corrected/communicated by the Case Manager by adding the weight goal to both care plans. To prevent recurrence, the CM Care Plan is now part of the Monthly Summary Progress Note binder to facilitate documentation and communication. Additionally, an in-service was provided to licensed staff regarding deficiencies and corrections as-well-as triggers related to weight goal and the addition of this information to the Monthly Summary Progress form. #1/2. To prevent recurrence, the CM-Care Plan is now part of the Monthly Summary Progress binder to facilitate documentation and communication. Triggers related to Weight Goal have been added to the Monthly Summary Nursing form. The licensed staff/DON completing the Monthly Nursing form are responsible to provide accurate information either by phone/visit to the physician/Case Manager.The Dietary Manager is responsible to communicate with the licensed staff/DON/Case Manager regarding a Weight Goal. The DON will oversee for compliance. Resident #1/#2: The deficiency was corrected/communicated by the Case Manager by adding the dehydration risk to both care plans. To prevent recurrence, the CM Care Plan is now part of the Monthly Summary Progress Note binder to facilitate documentation and communication. An in-service was provided to licensed staff regarding deficiencies and corrections as-well-as the inclusion of triggers related to dehydration that have been added to the Monthly Summary Progress form. #1/2. To prevent recurrence, the CM-Care Plan is now part of the Monthly Summary Program binder to facilitate the documentation and communication with physician and Case Manager. The licensed staff &/DON completing the Monthly Nursing Summary form are responsible to provide accurate information either by phone/visit to the physician & Case Manager.The Dietary Manager is responsible to communicate with the licensed staff/DON, and Case Manager regarding the dehydration risk. The DON will oversee for compliance. Resident #2: The deficiency was corrected/communicated by the Case Manager by adding dysphagia diagnosis and aspiration risk in CM Care Plan - #8. To prevent recurrence, the CM Care Plan is now part of the Monthly Summary Progress Note binder to facilitate documentation and communication. An in-service was provided to licensed staff regarding deficiencies and corrections, as-well-as triggers related to dysphagia and aspiration risk being added to the Monthly Summary Progress form.	04/02/2016 04/14/2016 06/28/2016 04/02/2016 04/14/2016 04/02/2016 04/14/2016

☒ §11-100.1-88 Case management qualifications and services. (c)(2)
Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:

Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;

FINDINGS
Resident #1 and Resident #2 – Nutrition care plan did not include weight goal.

Resident #1 and Resident #2 – Nutrition care plan did not address dehydration risk.

Resident #2 – Care plan did not address dysphagia diagnosis and aspiration risk.

11-100.1-88(c)(2). Resident #2. To prevent similar deficiencies from recurring, the licensed staff/DON completing the Monthly Nursing Summary are responsible to ensure ongoing/accurate communication either by phone/visit with the Case Manager. The Dietary Manager is responsible for communicating with the CM regarding a Nutritional Care Plan addressing i.e. dysphagia diagnosis and aspiration risk. The Monthly Nursing Summary Binder is a tool developed to hold the most current information. The Monthly Nursing Summary was updated to reflect the aforementioned process and responsibility. The Director of Nursing will oversee the above for compliance.

☒	§11-100.1-88 Case management qualifications and services. (c)(4) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions; **FINDINGS** Resident #2 – Nutrition care plan was not updated to include the resident's need for maximum assistance during meals.	Resident #2: The deficiency was corrected/communicated by the Case Manager by updating the residents care plan related to nutrition to include the resident's need for maximum assistance during meals. To prevent recurrence, the CM Care Plan is now part of the Monthly Summary Progress Note Binder to facilitate better documentation and communication between CM and staff. An in-service was provided to licensed staff regarding this deficiency and correction. #2. To prevent similar deficiencies from recurring, the licensed staff/DON completing the Monthly Nursing Summary are responsible to ensure accurate ongoing communication either by phone/visit with the physician/Case Manager. The Dietary Manager is responsible for communicating with the licensed staff and Case Manager regarding updates to the Care Plan including the need for maximum assistance during meals. The Monthly Summary Binder is a tool for maximizing information. The DON will oversee for compliance.	04/02/2016 04/14/2016 06/28/2016
☒	§11-100.1-23 Physical environment. (h) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers. **FINDINGS** Room 115 – A concrete post had a 2 inch chip.	Room 115: Maintenance repaired the post by properly following the recommended process of removing all peeling/flaking areas until post only had firmly adhered paint on it. A patching compound was used to even out the edges of the adhering paint. Sand paper was used to ensure there were no ridges or uneven edges. An oil based primer with stain-blocking properties was applied. Once primer was dry, the post was repainted to match existing post paint. To prevent deficiency from reoccurring, documented monthly inspections are being conducted and repairs are completed by maintenance staff.	02/24/2016 Monthly/On-Going
	Room 115 – Upper part of a wall had peeling paint. Room 117 – Parts of the wall had peeling paint. Room 219 – One (1) glass window was hanging crooked. Bed 221 B – Wall mounted signaling device unit was partially detached from the wall.	Room 115 and 117: Maintenance repaired the walls by by properly following the recommended process of removing all peeling/flaking areas until walls only had firmly adhered paint on it. A patching compound was used to even out the edges of the adhering paint. Sand paper was used to ensure there were no ridges or uneven edges. An oil based primer with stain-blocking properties was applied. Once primer was dry, the walls were repainted to match existing wall paint. To prevent deficiency from reoccurring, documented monthly inspections are being conducted and repairs are completed by maintenance staff.	02/24/2016 Monthly/On-Going

☒	§11-100.1-23 Physical environment. (h)(1)(D) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers. Housekeeping: All walls, ceilings, windows and fixtures shall be kept clean; and toilets and lavatories shall be cleaned and deodorized daily. **FINDINGS** Ground floor female common bathroom had a noticeable urine smell.	Room 219: The hanging glass window was adjusted and secured by maintenance the same day of inspection To prevent deficiency from reoccurring, documented monthly inspections are being conducted and repairs are completed by maintenance staff. Bed 221B: Maintenance mounted signaling device unit back in place the same day of inspection. To prevent deficiency from reoccurring, documented monthly inspections are being conducted and repairs are completed by maintenance staff. Female Bathroom: Trash bin for soiled briefs was full. Trash bin cover was left open thus allowing urine smell to emit. During inspection, Nurse Aid discarded bag of soiled briefs. Housekeeper disinfected and deodorized bin and bathroom floors to ensure there will be no noticeable urine smell. To prevent deficiency from reoccurring, Nursing will ensure lid is secured each time a brief is deposited into the bin. Housekeeping will continue daily and "as needed" disinfecting and deodorizing of bathrooms/bathroom floors.	02/19/2016 Monthly/On-Going 02/19/2016 Monthly/On-Going 02/19/2016 Monthly/On-Going
☒	§11-100.1-23 Physical environment. (i)(4)(A) All construction or alterations shall comply with current county building, land use and fire codes and ordinances in the state. The Type I ARCH licensed for wheelchair residents shall be accessible to and functional for the residents at the time of licensure. Lighting: Appropriate lighting fixtures adequate in number shall be provided for the comfort of residents and care givers; **FINDINGS** Room 115 – One (1) ceiling light fixture was not working.	Room 115: On the day of inspection. maintenance replaced the fluorescent ceiling light that was not working. To prevent deficiency from reoccurring, maintenance will conduct a daily round to ensure all light fixtures are working.	02/19/2016 On-Going

☒	§11-100.1-23 Physical environment. (o)(3)(B) Bedrooms: Bedroom furnishings: Each bed shall be supplied with a comfortable mattress cover, a pillow, pliable plastic pillow protector, pillow case, and an upper and lower sheet. A sheet blanket may be substituted for the top sheet when requested by the resident; **FINDINGS** Numerous pillows did not have plastic covers.	Plastic Pillow Covers: Following inspection, appropriate plastic pillow covers were ordered by the Housekeeping Manager. To date, they have not been received. Upon receipt, we will inform you of date of receipt and action taken. To prevent deficiency from reoccurring, an ample supply of appropriate plastic pillow covers will be maintained in the supply room where Nursing and/or Housekeeping will have access to replace any worn, discarded or laundered plastic covers in a timely manner. To prevent this deficiency from reoccurring, an ample supply defined at 12/ea plastic pillow protectors will be maintained in the supply room. The nurse aides and housekeeping staff are responsible to ensure that plastic pillow protectors are in place. The Director of Support Services is responsible to ensure compliance.	On-Going On-Going 05/05/2016

Licensee's/Administrator's Signature: _____

Print Name: Michael Warren, RN, BSN, MA
Director of Nursing/Care Home Operator

Date: April 15, 2016

Licensee's/Administrator's Signature: _____ RN DON

Print Name: MICHAEL A. WARREN RN DON

Date: 05/03/2017

Licensee's/Administrator's Signature: _____

Print Name: Michael Warren

Date: 04/17/2017

_____
4/17/17