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	125011	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE NANI REHABILITATION AND NURSING CENTEF	1677 PENSACOLA STREET HONOLULU, HI 96822

(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	Initial Comments A recertification survey was completed from 06/12-06/19/18. At the entrance conference there were 252 residents reported on the facility census. During this survey there were two complaints and one facility reported incident investigated and substantiated, ACTS# 6356, 6306 and 5318.	4 000		
4 098	11-94.1-21 Arrangement for services When the facility does not employ a qualified person to render a required or necessary service, it shall have a written agreement or contract with a qualified outside person or provider to provide the needed service. This Statute is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure that Resident (R)60 receive a device to maintain hearing abilities. The outcome is that R60 continues to struggle with any/all activities that require unimpaired hearing, including everyday communication. The deficient practice was only applicable to R60. Findings include: Interview with R60 on 06/12/18 at 02:18 PM who surveyor informed she is hard of hearing, and needs a hearing aid, asked about an hearing aid in the first month she was admitted but no follow up as far as she knows. Review of electronic health record reflected that on 04/11/18, staff (S)13 spoke to social worker regarding R60's hearing aid request. Interview with S14 on 06/15/18 at 10:41 AM who	4 098	1) Resident 60 audiology consult was ordered on 6/18/18. Social Service staff was educated by Administrator on 6/15/18 regarding follow through on residents who request for hearing services. 2) Residents residing in the facility requesting a hearing device have the potential to be affected. No other residents are currently requesting a hearing device. 3) DON/Designee re-educated licensed nurses on 7/6/18 regarding timely follow-up of residents' requests for devices to maintain hearing abilities. Social Services staff will be re-educated by Administrator on 7/16/18. 4) DON/Designee will conduct interviews of 5 residents per week x 4 weeks, then 3	8/3/18

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4 098	Continued From page 1 confirmed that she was assigned to R60 during April 2018, but did not recall R60 requesting a hearing aid. After S14 reviewed S13's 04/11/18 progress note, she explained that she recalled other details reflected in the progress note that day, but may have forgotten she was informed of the request for hearing aid. In summary, R60 did request for a hearing aid, communicated this need to S13, staff to staff communication documented resident's desire for a hearing aid, and S14 did not follow through on resident's request for hearing device.	4 098	residents per week x 2 months to validate that residents' requests for devices, if needed, have been met. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance. 5) Compliance will be achieved by 8/3/18.	
4 101	11-94.1-22(c) Medical record system (c) The following information shall be obtained and entered in the resident's record at the time of admission to the facility: (1) Personal information such as name, date, and time of admission, date and place of birth, citizenship status, marital status, social security number, or an admission number that can be used to identify the resident without use of name when the latter is desirable; (2) Name and address of next of kin, legal guardian, surrogate, or representative holding a power of attorney; (3) Sex, height, weight, race, and identifying marks; (4) Reason for admission or referral; (5) Language spoken and understood; (6) Information relevant to religious	4 101		8/3/18

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4 101	Continued From page 2 affiliation, if any; (7) Admission diagnosis, summary of prior medical care with listing of physicians providing care, recent physical examination, tuberculosis status, and physician's orders; and (8) Advanced directives, as applicable. This Statute is not met as evidenced by: Based on record review and interview, the facility failed to maintain a current, accurate Advanced Directive (AD) for Resident (R)81. As a result, there is potential that the wishes for healthcare for R81 may not be honored at the end of life. Findings Include: On Record Review 06/13/18, it was noted that R81 had an AD and Provider Orders for life-sustaining treatment (POLST) in the medical record. The POLST is a form designed to improve patient care by creating a portable medical order form that records the residents wishes so that healthcare personnel know what treatments the patient wants in the event of a medical emergency. A POLST is not an advance directive. R81's AD was signed and dated 06/20/16. It designated a friend as Health Care Power of Attorney and was marked to instruct health care providers to do the following: "1 A. Choice Not To Prolong Life." "I do want artificial nutrition and hydration regardless of my condition and regardless of the choice I made in question 1A/1B." "I do want treatment to alleviate pain or discomfort even if it hastens my death."	4 101	1) Resident 81 is no longer at the facility. 2) Residents currently residing in the facility who have formulated an advance directive will be reviewed to ensure that their current wishes are reflected on their advance directives. 3) Administrator will re-educate Social Service staff on 7/16/18 to ensure advance directives are reviewed at admission, quarterly, and as needed, for appropriateness. 4) Administrator/Designee will audit advanced directives for 5 residents per week x 4 weeks, then 3 residents per week x 2 months to validate that advanced directives are current and accurate. Administrator/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance. 5) Compliance will be achieved by 8/3/18.	

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4 101	Continued From page 3 The POLST orders in the medical record were incomplete. The POLST form was initiated on 04/04/17. It was signed by the physician, but was not signed by R81, or the designated Power of Attorney. These orders conflicted with the instructions for care outlined in the AD, and did not contain an order for artificial nutrition or comfort measures. A POLST that is not signed by the resident or Power of Attorney should not be in the medical record. 06/19/18 AM, the Staff (S)10 sought writer out to inform me "the friend of R81 would be coming in today to sign the POLST." I asked S10 if she was aware of the discrepancy of the content of the documents, and she replied that she was not. S10 stated, "I met with R81 and reviewed his wishes which are reflected correctly in the POLST." S10 stated she would follow up with the AD.	4 101		
4 125	11-94.1-27(14) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (14) The right to personal privacy and confidentiality of personal and clinical records; This Statute is not met as evidenced by: Based on staff interviews and a complaint made	4 125	1) Medical records that were given to	8/3/18

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4 125	Continued From page 4 to the State Department, the facility failed to protect against releasing resident (R) 157's identifiable information. Interview on June 13, 2018 with complaintee who stated that "they gave me the wrong paperwork". I was taking R157 to the doctor and the medical record given to me was on another resident. The paperwork included social security information, medications, personal information. The paperwork was handed back to me and I took it back to the hospital and gave it to the nurse. I pointed out the error. I talked to the woman in charge if social services. This complaintee was informed that any personal information on any other resident in the facility should not be in his possession. Interview on June 19, 2018 with Staff (S)1 who stated we reported this to our corporate office and he was given the packet of a different patient and there is an investigation going on with this. It was a mistake. We don't have a pattern with this happening here. That was identified by resident's boyfriend and he let the social worker know. He let the unit manager know and the unit manager retrieved it and it was shredded. The clinic did not call us. Instead they gave it back to the boyfriend. The unit manager followed up on this.	4 125	Resident 157 in error were retrieved and destroyed. Incident was referred to corporate compliance officer per company policy. 2) Residents who attend outside medical appointments have the potential to be affected. There have been no other reports of HIPPA violations. 3) Licensed Nurses were re-educated by DON/Designee on 7/6/18 to check packets to ensure the correct records accompany the resident prior to leaving the facility for their appointment. 4) Unit Manager/Designee will audit packets prior to resident going out to their appointments 5 times per week x 4 weeks, then 2 times per week x 2 month to ensure correct resident information is sent. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance. 5) Compliance to be achieved by 8/3/18.	
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use;	4 136		8/3/18

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4 136	Continued From page 5 (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on a complaint to the Office of Health Care Assurance, resident interviews, observation and staff interviews, the facility failed to provide quality of care that is a fundamental principle that applies to all treatment and care provided to facility residents. The facility must ensure that the residents receive treatment and care in accordance with professional standards of practice and the resident's choices. Findings include: 1) Interview on 06/12/18 at 11:12 AM, Resident (R) 29 stated that "staff will be standing in front of me and speaking Filipino . I have told them to speak English but they continue. They talk too much Filipino here. They talk so loud and this is not a playground. This is a hospital and you don't have to talk to loud outside and talk stories in Filipino". Interview on 06/13/18 at 0940 AM R223 stated "Communication here is a big problem. It is the main problem. They don't speak English here. Here, they speak Filipino in front of you. If there are two of them in the room, they will speak in Filipino. R223's wife stated that one of the staff addressed him as a patient who is dying". R223 further stated that "I don't like when they are	4 136	1) Staff assigned to Residents 29, 223, and 191 were re-educated on 6/12/18 and 6/13/18 regarding speaking English only when working in resident care areas. 2) Residents residing in the facility have the potential to be affected. Random resident interviews will be conducted by the Administrator/Designee on 5 residents per week x 4 weeks, then 3 residents per week x 2 months to validate that only English is spoken when staff are working in resident care areas. 3) Staff were re-educated by DON and Administrator on 6/28/18 and 7/31/18 to speak English only when working in resident care areas. 4) Administrator/Designee will conduct observations to validate compliance of staff speaking English only when working in resident care areas. Observations to include 8 floors/areas per week x 4 weeks, then 4 floors/areas per week x 2 months. Administrator/Designee will also update the Leadership Rounds form to include observation of the language used by the	

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4 136	Continued From page 6 speaking Filipino in front of me and it makes me upset". Observation on 06/13/18 at 1246 PM of three staff talking in Filipino at lunch area. Lunch area included residents and resident's families. Families passing by and family pushing client in wheelchair. Staff loud enough for everyone to hear from 20' away. Observation on 6/13/18 at 1330 PM of two staff members on Lewalani pushing bed near elevator. Observation on 6/15/18 at 10:54 AM where staff at door of Piikoi dietary location, talking in Filipino. Residents playing bingo on other side of screen. On 06/15/18, observation was made on Pensacola 2 of television stations on a Filipino station. R157 was on the phone, speaking in Filipino. She stated that "I am talking to my niece in the Phillipines". This tag does include a complaintant who notified the State Agency. The complainant stated that "Staff talk in Filipino here and have televisions on Filipino television stations. 2) On 06/12/18 attended the 10 am follow up Resident Council meeting with 9 residents (R8, R42, R93, R114, R133, R154, R175, R189, R220) present. This was a follow up meeting to discuss issues identified by residents from March 2018 and April 2018. During this meeting the residents brought up that staff at the facility speak Filipino to each other, in front of the residents, in the resident's room while providing care to the residents. Residents were reminded to bring this up right away with the unit manager and charge nurses and residents stated that even the nurses	4 136	staff to ensure compliance. Administrator/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance. 5) Compliance will be achieved by 8/3/18.	

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4 136	Continued From page 7 talk to each other in Filipino. Residents named staff that they witnessed speaking Filipino. Residents agreed that this was a facility wide problem. This issue has been addressed with staff at the facility with notification, training and signs are posted in the facility to speak English. Residents are concerned that staff speak Filipino in front of them and they do not understand what is being said. Following the meeting with the residents, requested a facility policy of language spoken at the facility fromS1 and S2. S2 stated that they do not have a facility policy on this but was able to give me a "7.1 English-Only Rules under VII. Miscellaneous Policies." This states "An English-only rule will be allowed only a) for communication with residents, residents' families, coworkers or supervisors who only speak English; b) in emergencies or to promote safety; c) for cooperative work assignments to promote efficiency; and d) to enable a supervisor who only speaks English to monitor the performance of an employee whose job duties require communication with coworkers or residents or their families if safety and/or effective operations require employees to speak English. No general policy will be approved that bans employees from speaking a language other than English during their break, lunch or other non-work time when not in resident areas." This was noted from Avalon Health Care Group-Hawaii Facilities. 3) During interview with R191 on 06/12/18 at 12:36 PM, R191 stated staff at the facility likes to speak in Filipino amongst themselves. R191 stated there are times when two staff are assisting him with care, they would speak in Filipino with each other right in front of him making him feel like they are talking about him.	4 136		

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4 136	Continued From page 8 R191 also stated he would frequently hear staff talking loudly in Filipino right outside his room door. R191 said his opinion is that this is America and staff should be speaking English especially during care of residents at the facility.	4 136		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on record review (RR) and staff interview the facility failed to develop and implement a baseline care plan within 5 days of admission for a resident (R111) who was readmitted to the	4 149	1) Resident 111 care plan was reviewed and updated by RN on 4/30/18. 2) Current residents' medical records were	8/3/18

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4 149	Continued From page 9 facility from an acute hospital with a stage 2 pressure ulcer (PU). Findings Include: On 06/15/18 at 09:40 AM during RR of R111 Electronic Medical Record (EMR) found that R111 returned to the facility on 4/24/18 with a principal diagnosis of Acute Hypoxemic Respiratory Failure. Upon further review it was found that R111 was discharged from the facility from 03/28/18 - 04/24/18, while he was admitted to an acute hospital and treated for suspected aspiration pneumonia. R111 returned to the facility with a stage 2 pressure ulcer (PU) to his sacroccygeal and redness to his scrotum. RR of R111 care plan (CP) did not show any baseline CP for the stage 2 PU. Interviewed S15 who confirmed that there was no baseline CP in place for R111 within 5 days after readmission to the facility. During this time it was noted that R111's CP for stage 2 PU was initiated on 4/30/18, which was 6 days after admission to the facility. RR of R111's Minimum Data Set (MDS) found that there was a Significant Change in Status Assessment documented in R111's EMR dated 4/29/18. Interviewed S16 who stated that CP for pressure ulcers are normaly started right away upon return from the acute hospital. S16 did not know why the CP for R111 was not started within 48 hours of readmission to the facility. When quiered about why R111 had a significant change in status, dated 4/29/18, S16 stated it was due to the new stage 2 PU on sacrum, decline in function, significant weight loss and R111 returned to facility with a Gastric Tube which was new.	4 149	reviewed to ensure baseline care plans are in place. 3) DON/Designee educated licensed nurses and interdisciplinary team members on 6/28/18 and 7/6/18 to develop and implement a baseline care plan within 48 hours of admission. The license nurse will initiate baseline care plans and during morning clinical meetings care plans will be reviewed for completion. 4) DON/Designee will conduct audits on residents who are readmitted to the facility weekly x 4 weeks, then monthly x 2 months to verify that baseline care plans were developed and implemented timely. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance. 5) Compliance will be achieved by 8/3/18.	
4 182	11-94.1-45(a) Dental services	4 182		8/3/18

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4 182	Continued From page 10 (a) Emergency and restorative dental services shall be available to each resident. This Statute is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide to ensure that Resident (R)60 receive routine dental care. The outcome is that R60 could not receive routine dental care because the annual dental consult was not rendered. The deficient practice was only applicable R60. Findings include: Interview with R60 on 06/12/18 at 02:13 PM who informed surveyor she wants a dental appointment for cleaning, has been begging social worker for toothpaste for sensitive teeth, and dental floss but has not received the service or items yet. Review of R60's electronic health record since admission to 06/15/18 did not reveal any dental services requested or rendered. Interview with Staff#14(S14) on 06/15/18 at 10:41 AM who confirmed that she was assigned to R60 during April 2018, but did not recall R60 requesting dental services. S14 said that dental consult is performed annually, but could not find that it was rendered in the health record for R60 who has been at the facility for more than a year. In summary, dental consults that are performed annually for routine dental care at the facility were not rendered for R60 who has been a resident at the facility for a year.	4 182	1) Resident 60 dental consult was requested. Dentist came on 6/18/18 and evaluated resident. Social Service staff was educated by Administrator on 6/15/18 to refer residents who want a dental consult promptly. 2) Residents residing in the facility have the potential to be affected. No other residents currently residing in the facility are requesting a dental consult. 3) Licensed nurses were educated by DON/Designee on 7/6/18 and Social Service staff will be educated by Administrator on 7/16/18 regarding facilitating routine and emergency dental care in a timely manner. 4) DSS/Designee will conduct random resident interviews of 5 residents per week x 4 weeks, then 3 residents per week x 2 months to validate that residents have been assisted in obtaining routine and emergency dental care. DSS/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance. 5) Compliance will be achieved by 8/3/18.	

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4 190	Continued From page 11	4 190		
4 190	11-94.1-46(g) Pharmaceutical services (g) Each drug shall be rechecked and identified immediately prior to administration. This Statute is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that the one resident (R127) was free from a significant medication error when her Blood Pressure (BP) medication was prepared and ready to be given after R127's BP (118/71) was taken and found to be outside of the ordered parameters that the medication can be given safely. This medication should have been held and documented. Findings Include: 1) On 06/14/18 at 11:05 AM observed S17 pull medications for R127. The following medications were put into a medication cup to be administered to R127: Aspirin 81 mg chewable tablet 1 tab, Losartan-HCTZ 50-12.5 mg tab 1 tab, Tamsulosin HCL 0.4 mg capsule 1 cap and Gavilax powder 17 GM which was mixed with water. S17 stated that R127's BP was 118/71. It was noted that on R127's Losartan HCTZ label that it stated "hold for SBP below 120." Quiered S17 about Losartan HCTZ if this medication should be given and she said no and disposed of the medication. On 06/14/18 after lunch requested facility policy on medication administration and this was given promptly by S2. Review of facility policy did not find any guidelines on when to hold medications per parameters that are ordered with blood pressure medications. 2) On 06/14/18 at 11:27 AM observed S17 gather	4 190	1.1) Licensed nurse for Resident 127 was re-educated by DSD on 6/14/18 regarding the need to follow blood pressure medication parameters as ordered. 1.2) Discard date on insulin pen for Resident (R) 157 was revised to 6/29/18 on 6/14/18. Discard date on Bacitracin eye drops for R 157 was revised to 7/26/18 on 6/13/18. Discard date on other eyedrops for R 157 was revised to 8/10/18 on 6/13/18. Vancomycin eye drops for resident R 157 were re-labeled to reflect correct eye for instillation. 2) Residents residing in the facility with blood pressure medication orders have been reviewed to ensure parameters are being followed. Also, residents residing in the facility with orders for eyedrops and insulin have the potential to be affected. Eyedrop and insulin labels have been checked to ensure correct labeling. 3) DON/Designee educated licensed nurses on 7/6/18 regarding safe medication administration to follow medication parameters and proper labeling of drugs. 4) DON/Designee will conduct audits on 10 residents per week x 4 weeks, then 5 residents per week x 2 months to validate	8/3/18

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	125011	A. BUILDING: _____ B. WING _____	06/19/2018

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4 190	Continued From page 12 supplies and medications needed to give R157. S17 stated that she had to give the resident 3 different eye drops and had to wait 3-5 minutes between the eye drops. After medication (Hydralazine 25 mg tablet 1 tab) was given to R157, per ordered parameter, (R157 BP was 159/77 and SBP was greater than 100) . S17 administered 3 different eye drops (Vancomycin 2.5% ophth drops, Moxifloxacin 0.5% eye drops, and Tobramycin-Dexameth ophth susp) to R157's left eye. Afterwards the eye drops were given to copy for this medication administration. It was noted that on the Vancomycin 2.5% ophth drops it stated "instill 1 drop into right eye 4 times a day." Inquired with S17 why this did not match the Medication Administration Record (MAR) and she took the eye drop to talk with her supervisor. Inquired with S15 why the Vancomycin 2.5% ophth drop label did not match the MAR and she stated that the medication came to the facility, from an outside pharmacy, not from PharMerica which is the facility's contract pharmacy, with that label and had not been sent to the pharmacy (PharMerica) for relabeling. S15 was able to print out the medication orders for R157 as requested. R157 had an order written on 06/01/2018 for Vancomycin 2.5% ophth drop instill 1 drop into left eye every 1 hour while awake, wait 5 minutes in between eye drop.	4 190	that residents with ordered blood pressure parameters were free of medication errors. In addition, UM will conduct medication pass observations 3x per week x 1 month to validate safe medication administration. DON/Designee will also conduct audits on 4 floors per week x 4 weeks, then 2 floors per week x 2 months to validate that discard dates on insulin and eye drops are correct. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance. 5) Compliance will be achieved by 8/3/18.	
4 205	11-94.1-53(b)(2) Infection control (b) The facility shall have provisions for isolating residents with infectious diseases until appropriate transfers can be made. (2) At least one single bedroom shall be designated as an isolation room as needed and	4 205		8/3/18

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4 205	Continued From page 13 shall have: (A) An adjoining toilet room with nurses' call system, a lavatory, and a toilet; (B) Appropriate hand-washing facilities available to all staff; and (C) Appropriate methods for cleaning and disposing of contaminated materials and equipment; This Statute is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to perform hand hygiene for one of four residents (Resident (R) 33 reviewed. This deficient practice put all the residents at risk for the development and transmission of communicable diseases and infections. Findings Include: 1) During a lunch meal observation of R33 on 06/12/18 at 12:47 PM, Staff (S) 8 assisted R33. S8 wiped the mouth of R33 with a napkin; however, S8 was not wearing any gloves and did not perform any hand hygiene before or after wiping R33's mouth. S8 proceeded to assist two other residents, again without performing any hand hygiene between residents. Again, this put the residents at risk for the development and transmission of communicable diseases and infections. During staff interview with S9 on 06/12/18 at 1:00 PM, S9 acknowledged that hand hygiene should always be done before and after assisting residents with meals.	4 205	1) Resident 33 did not experience a negative outcome. Staff was re-educated on 7/16/18 regarding proper hand hygiene practice. 2) Residents residing in the facility who require staff assistance with eating in the dining room and residents who come in contact with family members who fail to use PPE per guideline have the potential to be affected. Proper hand hygiene and PPE usage are currently in place in the dining room and on floors with isolation rooms. 3) DON/Designee educated licensed nurses on 7/6/18 regarding proper hand hygiene and PPE usage guidelines for employees and visitors. 4) DON/Designee will conduct dining room and isolation room observations 5 times per week x 4 weeks, then 3 times per week x 2 months to validate infection control practices are being followed. DON/Designee will report findings to QAPI	

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4 205	Continued From page 14 After review of facility policy on Hand Hygiene, the policy stated that "hand hygiene is the primary means of preventing the transmission of infection. Hand hygiene should be done before and after assisting a resident with meals. Hand hygiene should be done upon and after assisting a resident with personal care". This was not done. 2) Observed a man wearing a long sleeve yellow isolation gown and a face mask walking in the hall toward the Piikoi nursing station on 06/13/18 at 10 AM. During an interview on 06/14/18 at 10:30 AM with Staff (S) 5, I was informed the man was a family member of R116, who is on "contact precautions" for an Extended Spectrum Beta Lactamase (ESBL) infection. Contact precautions are special measures to prevent transmission of the infection which is spread by direct or indirect contact with the resident or resident's environment. S5 was asked what the facility policy was for visitors, and how they educate them on what special precautions they must take. S5 stated, " We don't have a written policy about visitors, but we put a sign on the door for them to check in at the nurses' station before entering the room. Every time a visitor comes, we go to the room and help them put on the gown and mask or what they need before going into the room." S5 stated, "Every time we remind them they need to take the gown and mask off, and wash their hands before they leave the room." S5 agreed the visitor should have taken off the gown and mask before leaving the room. 3) During an observation on 06/13/18, observed a family member (FM) enter a room marked for contact isolation without gowning. The room FM was entering was marked for contact isolation.	4 205	committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance. 5) Compliance will be achieved by 8/3/18.	

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4 205	Continued From page 15 Family member would go freely in and out of room to go to nursing station to ask questions of patient and step back into room. Upon questioning staff about "why does this FM not gown up?" Staff replied, "she has been doing this for a long time."	4 205		
4 220	11-94.1-55(g) Housekeeping (g) All combustible, potentially hazardous, or poisonous agents used for the cleaning of the facility shall be stored in a secured and locked area. This Statute is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to ensure the resident's environment is free of accident hazards, adequate supervision and assistance to prevent accidents. Findings Include: 1) During an observation of the Soiled Utility Room(SUR) (located on Piikoi two unit) on 06/12/18 at 09:48 AM, it was noted that the door to enter the room was not locked and anyone could have entered freely. There was also no staff in the immediate vicinity to prevent anyone from entering the room. The room had two large containers for soiled utility, three sharp containers; filled with sharps, two spray bottles of cleaning solution, and a four liter container of GaviLyte; which is a bowel prep solution used before medical test such as a colonoscopy. Any of these items would have put the safety of the residents and the public at risk for accident hazards. During an interview with Staff (S) on 06/12/18 at	4 220	1.1) The unit manager locked the soiled utility room immediately upon notification of it being open. The charge nurse and nurse aides on Piikoi Two were re-educated by the UM on 6/12/18 on the importance of locking soiled utility rooms to prevent risks to residents' safety. 1.2) Care plan for Resident 184 was reviewed to ensure that it remained appropriate. Resident has not experienced a change in behavior since the incident on 2/27/18. 2) Residents who experience a change in behavior have the potential to be affected. No current residents are currently exhibiting a change in behavior that requires close monitoring and could affect other residents. 3) Administrator re-educated staff on 6/26/18 on the importance of locking soiled utility rooms when not in use to	8/3/18

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4 220	Continued From page 16 09:55 AM, S7 stated that the door to the SUR should have been locked and secured. S7 also acknowledged the risk for accident hazards if the residents or the public got ahold of any of the items in the room. 2) Resident (R) 184 is a 75-year-old with a diagnosis of schizophrenia disorder. Completed RR of nursing notes, behavior monitoring form, care plan, provider notes, orders and medication administration records on 06/14/18 and 06/15/18. R 184 had a change in behavior with hallucinations and sleeping patterns on 02/15/18. On 02/16/18, Provider (P)1 ordered lab work to rule out infection or metabolic condition. P1 examined R184 that day. P2 also notified on 02/16/18 of R184's behavior. RR further reveals R184 had hallucinations and/or talking to himself every day the next ten days, as well as episodes of "afraid/panic, angry, danger to self, danger to others, "as noted on behavior form. P3 examined R184 sometime the morning of 02/26/18. Provider notes: "Assessment/Plan: ...seeming to be in acutely manic, psychotic episode, r/o delirium d/t acute change last 10-14 days.... Not currently evidencing imminent danger to self /others but will need CLOSE MONITORING of behaviors-pt lacks decisional capacity re: medical conditions as his judgement appears skewed by thinking that is not reality based." New orders were provided. 02/26/18 11:05 RR: "Resident sits in way of middle of hallway and refuses to be moved by staff for public to get by. Resident wheeled himself by the fire extinguisher ... and CNA staff reported him punching the glass." P1 notified and ordered an increase in the current medication (Depakote), and added Zyprexa, which is used for psychotic conditions.	4 220	prevent risks to residents' safety. DON/Designee educated licensed nurses on 7/6/18 regarding recognizing changes in resident behavior and interventions to implement to ensure safety of the resident and others. 4.1) Weekly Leadership Rounds form will be updated to include checking of soiled utility rooms to validate that the doors are locked. Director of Environmental Services (DES) will conduct an audit of 4 soiled utility rooms per week x 4 weeks, then 2 soiled utility rooms per week x 2 months. DES/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance. 4.2) UMs will conduct a weekly review of the 24-hour report x 3 months to validate that changes in resident behavior were identified and addressed in a timely manner. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance. 5) Compliance will be achieved by 8/3/18.	

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4 220	Continued From page 17 RR 02/27/18 07:50 Nurses note:" P2 updated regarding current condition (hurting self, yelling to kill, attempting to punch 2 residents and stood up without assistance) with order to give Zyprexa ..." P2 visited R184 that morning and wrote new orders." At 15:00 R 184 "yelled at a resident who passed by, and he was moved away from that resident ...". At 16:10 R184 got out of his wheelchair and struck R19. R19 was not injured and R184 was immediately removed from R19.	4 220		