STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125031	A. BUILDING: _____ B. WING _____	06/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOHALA HOSPITAL	54-383 HOSPITAL ROAD KAPAAU, HI 96755

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4 000	Initial Comments A relicensing survey was conducted from 05/21/2018, and became an extended survey due to substandard quality of care (SQC), with completion of the survey on 06/06/2018. The SQC was identified as Resident Abuse and Neglect. There were 20 residents on the facility census at the entrance conference with the hospital administrator.	4 000		
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 affiliation, if any; (7) Admission diagnosis, summary of prior	4 101		7/20/18

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4 101	Continued From page 1 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 electronic medical record (EMR) reviews and resident and staff interviews the facility did not obtain information and enter advanced directive into the resident's records at time of admission. Findings: 1) During an interview with R3 on 06/01/2018 at 11:05 AM, she stated she was not aware of what an AD was. R3 recalled signing papers when she was admitted in 2015, but denied having received any information about an AD. R3's EMR revealed she signed the facility's Patient Bill of Rights and Responsibilities on 11/20/2015 on admission to the facility, that included a paragraph, ". . . formulate and execute an Advance Directive, . . ." R3 had no AD found in her EMR. In addition, there was no documentation found in her record about staff discussing or providing the resident with any information about formulating an AD. The resident's brief interview for mental status (BIMS) was 15 which was documented on her 03/22/2018 minimum data set (MDS) quarterly review. A BIMS cognitive assessment score of 15 indicates that R3 is interviewable and can respond accurately to questions related to orientation and recall. 2) On 05/25/18 at 08:47 AM interviewed R15 and she was not aware of what an AD was. Provided brief explanation of AD to R15, who	4 101	4101 Medical Record System How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Social worker will educate/re-educate all residents of Advanced Directive by July 20, 2018. How the facility will identify other residents having the potential to be affected by the same deficient practice: Social worker will educate/re-educate all residents of Advance Directives and continue to do so every quarter and as needed. Results will be charted individually in resident□s chart. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. Social worker will evaluate all residents to assure everyone has the opportunity to draw up their advanced directive. Social worker will assist in-house residents with filing out their individual advanced directive. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. I.e. what program will be put into	

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4 101	Continued From page 2 stated that she received a form to read but at that time didn't know what she wanted, " I just don't want to be a burden to my children." On 06/04/18 at 12:58 PM R15's EMR had an AD designating her sons to make health-care decisions but instructions for health care was wholly unmarked except for notation under other wishes - "I want my sons, amongst themselves, to decide about my end of life care when the time comes." The resident signed and dated the AD form on 8/8/13. The MDS quarterly assessment on 12/05/2017 for R 15 had a BIMS summary score of 15. 3) On 05/24/18 at 03:15 PM 17's EMR had physician orders for life-sustaining treatment (POLST) but no advanced directives. At admission R 17 signed the Patient's Bill of Rights and Responsibilities on 1/19/15, that included a paragraph, " . . . formulate and execute an Advance Directive . . ." The MDS quarterly assessment for R 17 done on 05/09/18 had a BIMS summary score of 15. 4) On 05/25/18 at 08:38 AM interviewed R 19 and queried whether he had an AD. R 19 didn't know what an AD was but was asked at admission if he wanted resuscitation and told staff wanted to be full code. There was a POLST in 19's EMR and the resident signed the Patient's Bill of Rights and Responsibilities on 09/28/17 at admission. The MDS quarterly assessment for R 19 done on 03/19/18, had a BIMS summary score of 15. On 05/31/18 at 02:34 PM interviewed S2 regarding AD information provided to residents at admission and whether residents are provided information on developing or understanding what	4 101	place to monitor the continued effectiveness of the systemic change(s) Social worker will educate/re-educate all residents of Advance Directives and continue to do so every quarter and as needed. Results will be charted individually in resident□s chart.	

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4 101	Continued From page 3 advance directives are. According to S2, she thought an AD brochure was given at admission but needed to check with admissions staff. Review of the facility's AD policy and procedure, revealed the policy was that of another facility. On 6/4/2018, S1 was informed the AD policy provided to the SA was for another hospital. This policy required staff to have AD inquiry stickers and a questionnaire done, which was not being implemented at this facility. S2 was informed of this on 6/6/2018, but had no comment. Also, at the survey exit conference no AD brochure was provided.	4 101		
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 resident and staff interviews the facility failed to accommodate the preference for 1 of 22 residents (R) sampled (R15); and, provide reasonable accommodations for 4 of 22 residents sampled, in maintaining their dignity and	4 115	4 115 Residents Rights and facility practices (Sharing bathrooms) How corrective action will be accomplished for those residents found to	7/20/18

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4 115	Continued From page 4 well-being. Findings: Accommodate preference On 05/22/18 at 12:37 PM interviewed R15, and when queried if she had any other concerns at the facility she responded, " I don't like having to share bathroom with men." ON 05/25/18 at 09:13 AM, interviewed R15 and she reiterated that she wants to "share bathroom with ladies, " and she reported to Staff (S)1 on 05/24/18 about the male resident "dripping on the bathroom floor," in the adjoining bathroom that they share. R15 stated that when she uses the bathroom, she covers the urine drippings with paper towels. R15 further stated that the other male resident, doesn't close the shower curtain and wets the bathroom floor. According to R15, instead of addressing her concerns, S1 changed the subject. R15 further stated, "I don't think it's right that men share bathroom with women." Accommodate dignity and well-being 1) On 05/21/18 at 02:18 PM interviewed R18 and he complained that roommates's oxygen concentrator makes noise all day and that it was hard to sleep with the noise. During the interview observed that R18's roommate was provided continuous O2 and the O2 concentrator made continuous audible noises that could be heard from R18's bed. There was also strong bowel movement (BM) odor in the room and R18 stated that the BM odor is from the rubbish can. 2) On 05/22/18 at 09:42 AM, interviewed R19 and queried about bowel movement (BM) odor in facility and whether he noticed strong BM odors. According to R19 the BM odor was noticeable in	4 115	have been affected by the deficient practice: The LTC nursing manager will evaluate and switch the rooms to accommodate residents so that the female resident who does not want to share the restroom with males will not be required to do so. Two female residents who do not use bathroom facilities will be put in room with shared bathroom with males who do use the bathroom for the Kohala Hospital LTC facility of 22 beds. How the facility will identify other residents having the potential to be affected by the same deficient practice: The LTC nursing manager will monitor and evaluate all current residents, and room them so male and female residents who are functionally capable of using bathroom facilities are not roomed to share bathrooms with residents of opposite gender for the Kohala Hospital LTC facility of 22 beds. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. The LTC nursing manager will monitor and evaluate all incoming residents, and room them so male and female residents who are functionally capable of using bathroom facilities are not roomed to share bathrooms with residents of opposite gender for the Kohala Hospital LTC facility of 22 beds. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not	

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4 115	Continued From page 5 the room because the soiled briefs were in the room trash can and only sometimes staff would spray air freshener. 3) On 05/22/18 at 10:43 AM interviewed R5 and he stated that there is terrible BM odor in the bathroom. R5 also complained that noise in the facility came from a female resident that shared adjoining bathroom because she spoke loudly. On 05/25/18 at 8:15 AM interviewed S22 and he stated that trash cans in the long-term care (LTC) rooms were just emptied. S22 stated that depending on residents use of toilet, BM briefs will fill trash can especially if both residents in the room use briefs and are bedridden. S22 further stated that trash cans are emptied twice a day, in the morning and at 2:30 PM. The regular housekeeper was out sick during the survey timeframe and S22 was just following the usual routine for emptying trash. On 06/06/18 at 01:45 PM observed that the LTC unit hallway had BM odor that was prevalent as most residents were taking a nap and brief changes were being done. The soiled briefs were placed in closed trash containers but whenever staff opened the container to discard a soiled brief the odor emanated throughout the facility.	4 115	recur. I.e. what program will be put into place to monitor the continued effectiveness of the systemic change(s) P&P will be implemented to address this issue. Census reports will be reviewed by the LTC nurse manager/designee monthly to assure compliance with the new/updated policy and admission packet. Census reports and Resident council minutes will be evaluated for the next 6 months at Patient Quality and Safety Council (PQSC) to determine if further PDCA should be done for quality improvement due to same gender residents share the same bathroom. Effective date: July 20, 2018 4 115 Reasonable Accommodations Needs/Preferences (Oxygen Concentrator Noise) How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The LTC nurse manager will ensure that loud O2 concentrator is replaced with a new one. Will interview R18 and to determine if he believes this accommodation is sufficient to meet his needs/preference for a quieter living environment. If not, appropriate room changes will be considered. How the facility will identify other residents having the potential to be affected by the same deficient practice: The LTC nurse manager will ensure all of the newer, quieter O2 concentrators	

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4 115	Continued From page 6	4 115	replace the originals. RN manager will interview residents who share rooms where O2 concentrators are present to establish if residents are comfortable in their living environment. If not, appropriate room changes will be considered. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. The LTC nursing manager will follow up to ensure oxygen concentrators are okay with residents through patient rounding. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. I.e. what program will be put into place to monitor the continued effectiveness of the systemic change(s). Patient rounding reports and resident council minutes will be evaluated at the Patient Quality and Safety Council (PQSC) to determine if further PDCA should be done for quality improvement due to oxygen concentrator noise. Effective date: July 20, 2018. 4 115 Reasonable Accommodations Needs/Preferences (BM) How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Automatic air fresheners have been mounted in resident bathrooms to freshen. Nursing staff will communicate to housekeeping staff when soiled briefs are	

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4 115	Continued From page 7	4 115	deposited in trash, and housekeeping to remove trash promptly during daytime. After housekeeping hours, CNAs will remove trash with soiled briefs and put it in the soiled utility room. CNA staff will be educated and trained on tightly wrapping soiled briefs before putting them in the trash. The above practice(s) will impact the entire LTC ward of 22 beds. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have potential of being affected. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. Administrator/CNE/Designee will round with individual residents and ask if there are any BM odor in the living areas. Report will be generated and shared with Nursing Administration and housekeeping to help prevent BM odor from lingering. Follow-up with residents will also occur during residential council meeting by Administrator/CNE/Designee to address BM odors that linger. Automatic air fresheners have been mounted in resident bathrooms to freshen air. Nursing staff will communicate to housekeeping staff when soiled briefs are deposited in trash, and housekeeping to remove odorous trash promptly during daytime. After housekeeping hours, CNAs will remove trash with soiled briefs and put it in the soiled utility room. CNA staff will be educated and trained on	

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4 115	Continued From page 8	4 115	tightly wrapping soiled briefs before putting them in the trash. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. Administrator/CNE/Designee will round with individual residents and ask if there are any BM odor in the living areas. Report will be generated and shared with Nursing Administration and housekeeping to help prevent BM odor from lingering. Follow-up with residents will also occur during residential council meeting by Administrator/CNE/Designee to address BM odors that linger. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. I.e. what program will be put into place to monitor the continued effectiveness of the systemic change(s). Rounding reports and Resident council minutes will be evaluated for the next 6 months at Patient Quality and Safety Council (PQSC) to determine if further PDCA should be done for quality improvement due to BM odors lingering within living areas of the residents. Effective date: July 20, 2018	
4 120	1-94.1-27(9) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family,	4 120		7/20/18

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4 120	Continued From page 9 legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (9) The right to names, addresses, and telephone numbers of pertinent resident advocacy groups; This Statute is not met as evidenced by: Based on resident and staff interviews, and observations the facility failed to provide residents a list of all pertinent State regulatory, informational agencies and advocacy groups with contact information; and, information on filing grievances or complaints concerning any suspected violation of State or Federal nursing facility regulations in anonymity. Findings: On 05/23/18 at 10:24 AM, during the resident council interview, queried the eight resident council participants on their knowledge of filing grievances and complaints to the State office of health care assurance (OHCA), and/or advocacy groups (e.g. ombudsman, adult protective services [APS]). The participants stated that the nurse managers would assist them in filing any grievances/complaints, and provide to administration. Queried whether residents had knowledge of and/or access to OHCA, ombudsman and APS telephone numbers, address or email; residents were unaware where information could be found. On the facility's resident council minutes dated December 27, 2017 under the old business heading, . . . 5. . . . S1 mentioned that the facility staff will monitor all situations through the risk	4 120	4 120 Resident rights and facility practices (Skilled Nursing/ICF) How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The required notices and contact information was and is located at the entrance to the KH facility. All required notices and contact information are up to date including: A description of the manner of protecting personal funds; requirements and procedures for establishing eligibility for Medicaid; list of names, addresses, and telephone numbers of all pertinent State regulatory and informational agencies, resident advocate groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services and the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; statement that the resident may file a complaint with the State Survey Agency any suspected violation of state or federal nursing facility regulations.	

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4 120	Continued From page 10 management program and that he would receive incident reports daily on such items as falls, skin tears/bruises, . . . so that common causes could be found and acted upon proactively to keep residents safe and secure. Observed that the bulletin board that was accessible to the residents, at the entry hall to the dining/activity room (where the resident council meeting is held), there was no State OHCA, ombudsman, or APS contact information. On 05/23/19 at 4:22 PM, interviewed S1 and informed him that that residents didn't know that they could call the State OHCA, ombudsman, and/or APS directly to file a complaint and contact information was not accessible to residents. According to S1, he provided a brochure for filing grievance and/or complaints to residents and how it can be reported internally.	4 120	How the facility will identify other residents having the potential to be affected by the same deficient practice: The required notices and contact information was and is located at the entrance to the KH facility. All required notices and contact information are up to date including: A description of the manner of protecting personal funds; requirements and procedures for establishing eligibility for Medicaid; list of names, addresses, and telephone numbers of all pertinent State regulatory and informational agencies, resident advocate groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services and the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; statement that the resident may file a complaint with the State Survey Agency any suspected violation of state or federal nursing facility regulations. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. Kohala Hospital will add a second bulletin board to display the required notices and contact information in the dayroom where most of the residents visit for activities, religious services, resident council meetings etc. for it to be in closer proximity for residents and staff. Staff and residents will be educated on the location of the two bulletin boards and the importance of these notices.	

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4 120	Continued From page 11	4 120	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. I.e. what program will be put into place to monitor the continued effectiveness of the systemic change(s). The hospital administrator will continue to monitor compliance with this regulation on a quarterly basis per existing policy September 2013. Effective date: July 20, 2018	
4 135	11-94.1-29(f) Resident abuse, neglect, and misappropriation (f) If the alleged violation is verified, appropriate corrective action shall be taken to protect the resident's safety as well as other residents in the facility. This Statute is not met as evidenced by: The facility did not develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. Findings: Prohibit mistreatment and abuse of residents Based on resident and staff interviews, and observations the facility did not provide sufficient protection to prevent resident to resident abuse, as two male residents (R4 & R16) were allowed to wander into other residents' rooms and would touch residents, rummage through other's property and display sexually inappropriate behaviors. As a result, the residents	4 135	4 135 Free from Abuse and Neglect How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents found to be wandering into other residents rooms will be monitored to prevent them from disturbing other residents. Residents who have been disturbed in the past will be monitored and assessed for their perception of safety and privacy from wandering residents. Care plans of all of these mentioned residents will be updated to reflect these actions. Nursing staff has been re-educated via	7/20/18

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4 135	Continued From page 12 experienced ongoing mental abuse of fear, intimidation and agitation resulting in immediate jeopardy (IJ). On 05/23/2018 at 10:24 AM, the resident council interview was conducted. There were eight residents that participated in the resident council interview and the elected resident council president (R19) presided. The brief interview for mental status (BIMS) summary score averaged 14 out of 15 possible points for the resident council participants. The resident council interview questions included how the facility staff resolved any issues brought up at the monthly meeting, and R19 provided the prepared resident council agenda for May 23, 2018, that included, "Old Business for follow-up reports: Update regarding confused male resident who still enters our bedrooms, touches us, shuts our doors, fights with us, etc . . ." The resident council participants shared that there are two male residents that wander at night, and R19 stated that this issue will never be resolved because it's been on the resident council agenda every month for awhile now. The resident council participants shared their experiences with these two wandering male residents: R19 stated that R4 touched his feet while he was sleeping at night and was startled from sleep. "I have to yell at him to get out." R15 stated that R16 came into her room, pulled down his pants and showed his "private parts." "I yelled at him to put that back into your pants." R15 also stated that R4 came into her room and	4 135	in-service regarding monitoring, interventions, and documentation of wandering residents and protecting other residents. 1-1 staffing has been assigned to identified wandering residents during eve and night shifts. Activity staff, support staff, and volunteers have been educated not to leave wandering residents alone. Activity staff to increase activities for wandering residents per these residents preferences. How the facility will identify other residents having the potential to be affected by the same deficient practice: RN manager to attend resident council meetings and clinical staff to report to RN manager to identify any other residents having potentially been affected. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. Residents found to be wandering into other residents rooms will be monitored to prevent them from disturbing other residents. Residents who have been disturbed in the past will be monitored and assessed for their perception of safety and privacy from wandering residents. Care plans of all of these mentioned residents will be updated to reflect these actions. 1-1 staffing has been assigned to identified wandering residents during eve and night shifts. Activity staff, support staff, and volunteers have been instructed not to leave wandering residents alone. Activity staff to increase activities for wandering residents per these residents preferences.	

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4 135	Continued From page 13 told her that she's sleeping in his bed. When asked what did she do, R15 stated, "I yelled at him to get out of my room, I've had this bed for over 5 years." R15 also stated that R4 would wheel himself to her roommates bed and stare at her sleeping with her legs spread open. "I tell him to leave and he leaves after he gets his full." R8 stated, "I call the nurse when R4 comes into my room." When asked if staff come right away, R8 stated, "Sometimes." Queried R8 if she was afraid when R4 came into her room, and she nodded her head in answer - Yes. R8 stated that for some reason R4 likes to rummage through other residents possessions and took her water pitcher. R14 stated, " I just yell, get out, what else can do, no can do nothing about it." R19 stated that R16 would stand just outside the doorway of his room and peer at him and felt spooked by his shadow. R13 nodded his head in agreement as had the same experience as R4 also touched his feet while he was sleeping. The male resident council participants stated that they would have to yell at these wandering male residents to get out of their room. R19 didn't understand why R4 had access to his wheelchair at night and allowed to roam the facility. According to R15, R16 could ambulate and should be using his front wheel walker but usually just ambles down the hallway to her room and doesn't listen to staff. On 05/23/18 at 02:12 PM observed R16 walking unassisted into the activity/dining room. There was no staff in the activity/dining area and R16 sat in the back of the room by himself and there	4 135	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. I.e. what program will be put into place to monitor the continued effectiveness of the systemic change(s). Monthly care plan updates and medication reviews. Psych evals of wandering residents to assess and address any need for medication adjustments and/or psychiatry interventions. Administration and nursing leaders to round on residents who have verbalized concerns re: wandering residents. Effective date: 07/20/18	

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4 135	Continued From page 14	4 135		

was another resident sitting toward the front watching TV.

On 05/23/18 at 2:30 PM interviewed S12, and she confirmed from resident council meeting minutes that there are two male residents that wander throughout the facility. According to S12, R4 and R16 enter residents rooms while they are sleeping and some residents report that they are touched by these residents. "I'm not sure how they are touched, and residents also reported that they make noise when they are sleeping." S12 also stated that R16 is known to shut the door of other residents' room and fights with them, R16 "hits." When queried about sexual behaviors displayed by these residents, S12 related that was told by another male resident (that is no longer in the facility), that R16 pulled the blanket off of him and was rubbing his thigh. S12 also stated that R16 exposes himself to other residents. S12 further stated that the facility administrator is aware that R16 walks into other residents' rooms and that he roams more evening and night shift. R4 enters other residents' rooms with his wheelchair but S12 never saw him to be aggressive. S12 stated that resident council minutes for March and April would show these incidents too.

On 05/23/18 at 3:40 PM interviewed S1 and notified him of the immediate jeopardy. Informed S1 of resident council interview and how the residents at the meeting talked about the unresolved issue of the confused male resident that enters their rooms. S1 stated that the issue never goes away from old business even if it was updated. The latest update to that issue, that S1 could recall, was that R16 is now isolated and has his own room closest to the nurses station. To manage R16, a bed alarm was placed, the facility

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4 135	Continued From page 15 tried to transfer him to another facility with a locked unit, and had geri-psych consults done to stabilize his behaviors with medications. S1 acknowledged that R16 still roams at night and that the nurse manager that was monitoring the behaviors and providing updates no longer works at the facility. S1 acknowledged that, "The problem is still here." Interviewed S2 and she stated that the former nurse manager attended the resident council meetings and that they were aware of the issues. S2 did receive reports that R4 and R16 goes into other residents' rooms and stated that they were trying to discharge R16 but it was difficult because other facilities don't want a wanderer with sexual behaviors and the resident being very tall. On 05/24/18 requested the resident council meeting minutes from the activity director and she provided the agenda and minutes from 12/2017 to 04/25/2018 (there was none for 02/2018), on the minutes for: 12/27/2017 under Old Business heading . . . "5. Confused resident bothering & entering other residents' rooms. Staff will be working on updating his care plan to alleviate unwanted behavior. . . ;" 01/31/2018 under Old Business heading . . . "f. Why is R16 still allowed to roam at night, entering rooms, physically touching & bothering a number of residents? Residents are fearful for their safety;" 03/07/2018 under Old Business heading . . . "5. Confused resident keeps entering others rooms, touching them, safety concerns. When is this going to be taken care of. A grievance report was filed in February on this concern. What is the status of this grievance report?";	4 135		

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4 135	Continued From page 16 04/25/2018 under Old business for follow up reports . . . "Alternative placement for confused resident who enters others rooms." On 05/24/18 at 3:09 PM interviewed S53 and he has witnessed and have caught R4 and R16 right before they attempt to enter other resident' rooms but cannot always stop them because, "I get busy with other things." S53 stated that he can't stop them from wandering around, but have to try when they go into someone's room. On 05/25/18 at 09:20 AM the survey team accepted the finalized IJ abatement plan. Prohibit Neglect Based on observation, record review and interviews, the facility did not ensure that each resident's environment remains as free of accident hazards as is possible and failed to ensure each resident receives safe, adequate supervision and assistance devices to prevent accidents for 4 of 19 residents (R16, R4, R14, R7) in the sample. Findings Include: 1) On 05/23/18 at 2:12 PM, R16 was observed walking unaccompanied into the activity room. He sat in a chair at the back of the room by himself. R16 stared, smiled and appeared tired. Another resident, R14, sat in the front of the room by the TV. There was no one in the activity room to monitor these residents. On 5/23/2018 at 2:30 PM, interview with S12 was done. S12 said that R16 requires staff supervision when he goes out of his room. As for the observation this morning where R16 was	4 135		

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found without any staff, S12 stated, "I gonna be honest with you, he lifted his walker and threw it down, I went there and said can somebody go in there and monitor him when I make (R14's) coffee. Nobody like monitor patients when they are outside. They called me and said (R16) walking in the day room. They just let him walk." She recalled for the January resident to resident altercation, R16 hit R4, that he fights with other residents and also hit a former resident no longer at the facility.

S12 said R16 roams around more in the evening and night. S12 said he also has sexual behaviors of exposing himself and touching others. S12 confirmed that R16 should be supervised when he walked around and supervised whenever he was left alone, but it was not being done. Regarding the 2/27/18 event report of R16's elopement out of the facility's door at 4:00 AM, S12 said administration is aware that R16 walks around unsupervised and into other residents' rooms, but they did not care about it. R16's current care plan did not address the elopement, aggression toward other residents and unsupervised wandering with specific interventions.

Random observations of R16 during the survey found him either in his room or the activity room. After the IJ was identified and abated on 5/25/18, the facility provided a patient caregiver ratio of 1:1 for supervision of the resident.

2) S12 was asked about R4's right ankle fracture he sustained in March 2018. S12 said R4 was put in the wrong wheelchair because his wheelchair was broken. S12 said this was not communicated and that the fracture to his foot could have been avoided. S12 said, "but they no

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say anything, so I told them why don't you say anything about this is the wrong wheelchair." S12 said because it was the wrong wheelchair, he slid out of it. A 3/1/2018 note stated the resident slid off his temporary new wheelchair with swelling to his right ankle noted on 3/2/18. An x-ray confirmed he sustained a fracture to his right ankle.

Random observations of R4 during the survey found he was able to propel himself in his current wheelchair through the hallways and around the facility. R4 was also one of the two residents whom the other Resident Council participants (R8, R19, R13, R14, R15 and R18) identified as being someone who entered their rooms at night, touched their feet and/or stared at them. R4's current care plan failed to specifically address his behaviors and unsupervised wandering although staff were aware of it.

On 05/24/18 at 10:12 AM interview with S52 was done. S52 said R4 was the more active resident who went into other residents' rooms, got into fights with them and touched their feet. S52 verified it was more than several residents who had complained about R16's and R4's behaviors and named R19, R15, R8 and R14 as some of those residents who have been complaining about it for a long time.

Interview of S1 on 05/23/18 at 3:40 PM revealed he was aware that R16 "still roams at night." S1 was asked about the second resident, R4, who also went into other residents' rooms. S1 agreed that without care plans, which S1 stated was the map to guide their staff, this was still a problem. After the IJ was identified and abated on 5/25/2018, the facility provided a patient caregiver ratio of 1:1 to closely monitor R4.

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4 135	Continued From page 19 3) On 05/24/18 at 08:34 AM, the SA observed R14 wheeling himself outside of the main facility entrance. The resident's wanderguard sounded but the resident continued to wheel himself toward the left upper part of the parking lot. He was unsupervised and no staff came to attend to him. He turned his wheelchair around and then proceeded to free wheel down the parking lot. His wheelchair took to taking a left angle curve and once he plateaued, he wheeled himself to the right side of the parking lot. He continued this routine once more more around the parking lot. When he was done, R14 wheeled himself back to the facility entrance. The SA asked him if he was able to see and he said no, that he could only see through one eye, but could see the "yellow" on the entrance door. He said he was able to stop his wheelchair, but said he fell out of his wheelchair once. S1 who came out to meet the SA and observed R14's activity, stated the resident "can fly" on his wheelchair. S1 said the resident did this as part of his daily exercise routine if it did not rain. R14 was observed to have impaired vision and a below the knee amputation of his right leg. S1 was asked whether R14 had been assessed for his safety to do this, but S1 was uncertain. R14 had no helmet on, but donned a reflective vest and had a orange flag on his wheelchair. S1 acknowledged the resident had a "back flip type of roll" out of his wheelchair. S1 produced R14's accident event report per SA's request. It stated two visitors heard the fall outside and one visitor held R14's head "as he had hit back of head on asphalt." The report stated, ". . . he was headed uphill in wheelchair (w/c) from carport, almost to top, slipped backwards out of w/c.	4 135		

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4 135	Continued From page 20 Concrete/asphalt wet from rain." The recommendation was to place anti-tips on the wheelchair, which the resident currently has. However, EMR review of R14's record found there was no updated care plan which included fall prevention interventions after his wheelchair accident on 5/1/2017. After the SA queried whether a safety assessment was done for R14, the facility did an occupational screen on 5/24/2018. Prior to this, there had been no comprehensive assessment nor care plan revision to ensure for this 92 year old resident's safe supervision after his 2017 fall in the parking lot. During an interview with S3 on the morning of 6/05/2018, S3 stated it was good this resident was now being reviewed for his safety. S3 said "it's been a concern long time." S3 said it got dangerous in the parking lot for R14 when cars and delivery trucks came through with no one out there supervising him.	4 135		
4 155	11-94.1-40(c) Dietary services (c) A nutritional assessment and care plan shall be recorded in each resident's medical record and integrated into the overall comprehensive assessment and overall plan of care coordinated/integrated with all disciplines. The nutritional assessment and care plan shall be reviewed on a regular basis and adjusted as needed. This Statute is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure that a resident receiving enteral nutrition maintains acceptable parameters of nutritional status for 1 resident.	4 155	4 155 Nutrition How corrective action will be accomplished for those residents found to have been affected by the deficient	7/20/18

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4 155	Continued From page 21 Findings Include: R6 was readmitted to the long term care unit (LTC) on 1/2/2018 from the facility's adjoining acute hospital. On 1/4/2018 due to aspiration concerns, R6 was placed on enteral nutrition (EN) only of Fibersource. The EN was given via his gastrostomy tube (GT or feeding tube). Initial observation of R6 on 05/22/2018 at 09:46 AM found R6 with a GT bag labeled with the EN formula Promote. R6 was not able to converse, appeared thin and his mouth was open. R6's admitting diagnosis was difficulty swallowing following a stroke. Review of R6's EMR weight record found he experienced unplanned weight loss within the first month of his readmission to the facility. A 1/2/2018 readmission weight could not be found. R6's 1/1/2018 hospital weight was taken at 145 pounds (lbs). R6's next recorded 1/26/2018 weight was 135 lbs, and four days later on 1/29/2018, his weight was 129 lbs. A 1/9/2018 plan of care intervention stated, "If weight changes plus/minus three pounds, reweigh and inform charge nurse of weight changes." There was a 6 lb weight loss in four days in January alone. Yet, no clinical documentation was found for the resident's drop in weight over four days, nor did the facility reweigh the resident. On 6/6/18, S6 confirmed R6's readmission weight was not done and they failed to follow the care plan interventions. Also, review of a 1/7/2018 nursing entry documented R6's EN Fibersource "run out." The entry noted that S35 ordered the EN formula be changed to Promote with Fiber and to confirm	4 155	practice: Assistant Nurse Manager will review weight assessment entries of affected residents at KH for accuracy of data entry and will ensure hard copies of weight assessments have been entered into EMR. Re: MDS error, please see corrective action of F640. How the facility will identify other residents having the potential to be affected by the same deficient practice: Assistant Nurse Manager will review weight assessment entries of all residents at KH for accuracy of data entry and will ensure hard copies of weight assessments have been entered into EMR. Experienced consultant (former MDS coordinator of KH) will review all LTC residents to assure MDS was completed. All MDS due will be completed by June 28, 2018. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. RN Educator will provide mandatory in-service to clinical staff regarding accurate weighing of residents, reporting of weight changes, interventions with weight discrepancies, and documentation. Rehab personnel will provide hands-on demonstration of use of various scales. MDS will be done by the interdisciplinary team: nurses, therapist, activities, dietary, and social services. RN consultant will in-service other disciplines on the MDS by July 20, 2018.	

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4 155	Continued From page 22 with the dietitian. On 1/26/2018, the Registered Dietitian's (RD) nutritional evaluation noted the switch to Promote at four feedings a day. The RD calculated and wrote the kilocalories/protein amount which the Promote would provide, but that it would be less than what the resident had been receiving. She further wrote, "When formula is available, recommend change to feedings of Jevity 1.5 at 4 feedings per day for 1500 Kcal and 64 G pro with 800 ml fluid to meet his full estimated needs. . ." Her general comments said, "With change of formula his current feedings will not meet his full needs. Recommend change to Jevity 1.5." The EN flowsheet showed the EN formula changed from Fibersource to Promote with fiber 1 can x 4 cans/day on 1/10/2018. But, the physician's order to change the Fibersource to EN Promote 1.0 was dated 1/30/2018, 20 days after the start of the Promote formula. Thus, staff started a new EN formula without a physician order. By the end of January, the resident's weight showed a 6 lb weight loss. The RD's next 4/9/18 entry stated, "Advance to feedings of Jevity 1.5 at goal of 1 can x 4 feedings per day to meet his full estimated needs. Will monitor at least quarterly while he remains at Kohala hospital." Yet, the EN formula R6 continued to receive was Promote, and not the Jevity recommended by the RD in January. The RD and the IDT failed to review the EN flowsheets and thus did not identify this in their April quarterly review as well. On 05/31/18 at 11:11 AM, interview with S5 was done. She verified her 5/11/18 nursing entry stating, "todays 119.6 lbs a weight loss of 10	4 155	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. I.e. what program will be put into place to monitor the continued effectiveness of the systemic change(s). Assistant Nurse Manager will monitor weight assessment, documentation, and intervention activities of clinical staff to ensure accuracy and compliance. RN educator will educate all nurses to perform a Monthly Review of their assigned residents and provide the necessary data to the MDS/RAI coordinator monthly. The nurse manager will assure that a 24 hour, 14 day, and 120 days assessment/care plan is done timely for admission, change of status, significant change, ADL decline, etc. RN manager will report to the LTC nurse manager on number of MDS assessments and care plans deadlines and submissions. PDCA will be done through the Patient Safety and Quality Council meeting. Effective date: July 20, 2018. 4 155 Nutrition/Hydration Status Maintenance How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Affected resident has received new formula with increased calorie concentration starting 6/1/18. Since 5/17, resident□s weight has increased by 3 lb from 119 to 122 lb on 5/24. Resident is weighed weekly, and accuracy of weights	

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4 155	Continued From page 23 pounds. . . reweighed at day shift 120.5 lb. . ." S5 produced her 5/11/2018 report sheet that showed R6's weight had trended down from 140, 130 and to 119.6 lbs. S5 said those weights were reported by the night shift nurse to her. S5 verified she was supposed to have notified the RD about this 10 pound weight loss, but failed to do so. When S5 was asked whether S35 was notified per her nursing entry, she recalled having spoken to him and said, "He (S35) wanted to add another can and whatever we had before because it had more calories than the one we're giving (R6) now." S5 stated looking at R6's weight record, it was a real concern for the amount of weight loss the resident experienced since his readmission. During an interview with S35 on 05/31/18 at 3:34 PM, he concurred the clinical documentation on the R6's weight record was inconsistent. S35 said the accuracy of recording the residents' weights overall has been an issue at this facility. S35 also produced a copy of a May 10th nursing communication note which verified S5's interview regarding the night shift nurse's report of R6's current weight at 119.5 lbs, with a noted 10 lb weight loss from April to May. It also stated, "Note previous formula was twice the calories compared to promote - suggest increasing calories/feeding will weigh weekly" and that S35 was made aware, but had no new orders. By the April 2018 quarterly review, R6's weight loss trend still had not been recognized. The documentation revealed R6's February 2018 weight was missing, and although his weight remained at 130 lbs for March and April, a 4/16/2018 entry documented the resident's weight at 237 lbs. Then by the next recorded weight on	4 155	is verified by Assistant nurse Manager. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are to be weighed weekly, for a three month period of time in order to establish a trend of accuracy and consistency. Assistant nurse manager will review weights of all residents, identify any significant changes, and notify hospitalist of any weight loss of 5 lb or more. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. RN Educator will provide in-service to all clinical staff regarding nutrition and hydration status maintenance in LTC residents. Charge nurse will ensure that weights are obtained thoroughly and accurately before the end of his/her shift. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. I.e. what program will be put into place to monitor the continued effectiveness of the systemic change(s). Assistant Nurse Manager will receive weight reports from RN at Daily Clinical Operations, verify charting, and check trends. Assistant nurse manager will monitor weights weekly. RN educator will provide education regarding nutrition and hydration maintenance to all clinical staff and eduction regarding weighing and documenting accurately. Effective date: July 20, 2018.	

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4 155	Continued From page 24 5/12/2018, his weight dropped to 123 pounds. The last weight entry on 5/17/2018 showed R6's weight at 120 pounds. The discrepancies in the weight documentation alone showed staff were not reviewing nor monitoring this. S8 said during an interview on 5/30/18 that R6's weight loss total of approximately 25 lbs from his readmission to his last recorded weight of 5/17/2018 was a concern. S8 stated for R6 receiving scheduled EN nutrition, "It's not like we were feeding him and he shouldn't have that, unless something else was going on." For a resident on EN bolus feedings, coupled with a lack of clinical oversight, a lack of following care plan interventions, and inaccurate documentation/ lack of communication, R6 was found to have experienced unplanned, significant weight loss that potentially could have been avoidable. Cross-reference to F580, F657.	4 155		
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on observation, record review and interview, the facility failed to review and revise the care plans for each resident to ensure it reflected a person-centered, comprehensive care plan, based on the interdisciplinary team (IDT) assessment for 8 of 19 (R4, R16, R8, R15, R19, R13, R14, and R6) in the sample.	4 175	4 175 Interdisciplinary care process How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Hired an experienced MDS/RAI	7/20/18

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4 175	Continued From page 25 Findings Include: 1) Cross-reference to findings at F600 and F689. R4's diagnosis included unspecified dementia with behavioral disturbances. During random observations of R4, he was able to self propel himself while in his wheelchair throughout the long term care (LTC) unit where he resides and to the adjoining critical access hospital (CAH) area. R4 was identified however, as one of two residents whom several residents identified as being intrusive, came into their rooms and/or touched them while they were asleep. S1 and S2 acknowledged this resident had the ability to go around the units. The Resident Council Minutes documented R4 had been doing this as far back as January 2018. During review of R4's care plan on 5/23/18, and despite the facility's knowledge of the resident's behaviors, his care plan had not been revised/updated to include a problem with interventions to prevent these inappropriate behaviors. His plan of care included generic interventions such as place patient close to nursing station, place wander guard device on patient, provide protective environment, etc. On 5/23/2018 at 1:40 PM, S9 confirmed these interventions/"plans" were current. After the IJ was identified, the facility reassessed and revised R4's care plan to include interventions to ensure for R4's safety, supervision and the safety of all other residents. 2) Similar to R4, R16 had been identified by various residents as someone who wandered into their rooms without permission. As part of the IJ and abatement plan, the facility also reassessed this resident. His care plan was revised to	4 175	coordinator to educate/in-service the MDS nursing staff. Nurse manager, Assistant Nurse Manager, and RN educator on MDS/RAI process to complete MDS and care plans in a timely manner. How the facility will identify other residents having the potential to be affected by the same deficient practice: Experienced consultant (former MDS coordinator of KH) will review all LTC residents to assure MDS was completed. All MDS due will be completed by June 28, 2018. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. MDS will be done by the interdisciplinary team: nurses, therapist, activities, dietary, and social services. RN consultant will in-service other disciplines on the MDS by July 20, 2018. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. I.e. what program will be put into place to monitor the continued effectiveness of the systemic change(s). RN educator will in-service all nurses to perform a Monthly Review of their assigned residents and provide the necessary data to the MDS/RAI coordinator monthly. The nurse manager will assure that a 24 hour, 14 day, and 120 days assessment/care plan is done timely for admission, change of status, significant change, ADL decline, etc. RN manager will report to the LTC nurse manager on	

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4 175	Continued From page 26 include interventions for a patient caregiver ratio of 1:1 due to his wandering and known inappropriate behaviors (aggression and sexual), and for the safety of all other residents. 3) R8, R15, R19, R13 and R14 whose care plans had not been revised, but were those residents who expressed on-going concerns about R4 and R16, had their care plans updated as part of the IJ and abatement. The facility had failed to do this. 4) R14's care plan review found it had not been updated/revised to include supervision or safety measures related to R14's daily wheelchair exercises he did in the parking lot. This was found after the SA's observation of the resident during the survey and his record review. 5) R6 was readmitted to the facility on 1/2/2018 with a diagnosis of difficulty swallowing following a stroke. Cross-reference to findings at F692. R6's care plan had not been updated to include the monitoring of his nutritional status after the dietitian's January 2018 evaluation to advance his enteral nutrition (EN) to Jevity 1.5, 1 can x 4 feedings per day to meet his full estimated needs. The IDT failed to review and revise his nutrition care plan, as the resident remained on an EN formula (Promote) that provided a mid to lower range of his estimated needs as found in the 1/26/2018 nutrition evaluation.	4 175	number of MDS assessments and care plans deadlines and submissions. PDCA will be done through the Patient Safety and Quality Council meeting. Effective date: July 20, 2018. 4 175 Interdisciplinary care process How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Hired an experienced MDS/RAI coordinator to educate/in-service the MDS nursing staff. Nurse Manager, Assistant Nurse Manager, and RN educator on MDS/RAI process to complete MDS and care plans in a timely manner. How the facility will identify other residents having the potential to be affected by the same deficient practice: Experienced consultant (former MDS coordinator of KH) will review all LTC residents to assure MDS was completed. All MDS due will be completed by June 28, 2018. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. MDS will be done by the interdisciplinary team: nurses, therapist, activities, dietary, and social services. RN consultant will in-service other disciplines on the MDS by July 20, 2018. How the facility will monitor its corrective actions to ensure that the deficient	

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4 175	Continued From page 27	4 175	practice is being corrected and will not recur. I.e. what program will be put into place to monitor the continued effectiveness of the systemic change(s). RN educator will in-service all nurses to perform a Monthly Review of their assigned residents and provide the necessary data to the MDS/RAI coordinator monthly. The nurse manager will assure that a 24 hour, 14 day, and 120 days assessment/care plan is done timely for admission, change of status, significant change, ADL decline, etc. RN manager will report to the LTC nurse manager on number of MDS assessments and care plans deadlines and submissions. PDCA will be done through the Patient Safety and Quality Council meeting. Effective date: July 20, 2018.	
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	4 177		7/20/18

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4 177	Continued From page 28 the resident to adapt and function within the resident's environment. This Statute is not met as evidenced by: Based on resident and staff interviews and EMR reviews the facility failed to provide physical therapy services and range of motion exercises (ROM) for 1 of 19 residents (R19) sampled for the survey. Findings: On 05/21/18 at 01:53 PM, screened R19 and resident stated that has left sided weakness after having a stroke last March 2017. On 05/22/18 at 09:51 AM interviewed R19 and resident stated that CNAs don't do ROM although it's part of his CP. On 05/25/18 at 08:26 AM interviewed R19 in his room and he couldn't understand why his wheelchair couldn't be kept at his bedside like other residents, that roam around the facility all day and night. R19 was also upset about not having physical therapy (PT) and felt that rehab couldn't happen when not able to exercise and use cane to walk. R19 claimed that he received Medicaid insurance two weeks from the date and couldn't understand why PT wasn't restarted as it was discontinued due to no insurance coverage. R19 claimed that he didn't walk this week because not enough staff, and CNAs supposed to walk with him after lunch. Also, the staff were supposed to be doing ROM so he doesn't have spasms, but no one does it. The occupational therapist showed staff how to do ROM a month ago but no one comes to do it.	4 177	4 177 Specialized rehab services How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Therapy immediately re-started on resident. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the same deficient practice. Therapy department will ensure all residents who verbalize desire for rehab are screened for needs. Upon indication of need for rehab services, services will start promptly and continue regardless of insurance authorization as long as therapy continues to be appropriate per rehab department assessment of need. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. Therapy department will establish a schedule in which to screen all residents on a quarterly basis. If therapy need is identified by rehab department services will start promptly and continue regardless of insurance authorization as long as therapy continues to be appropriate per rehab department assessment of need.	

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4 177	Continued From page 29 On 05/25/18 at 09:45 AM Interviewed S54 and inquired about PT for R19 and she stated that his med insurance didn't give authorization for PT, and she was "bummed" too. On 05/25/18 at 10:09 AM reviewed R19's EMR and found that resident had medical insurance. Queried R19 on who told him that he was covered by Medicaid and R19 stated that he saw the card and the business office was holding it. On 05/25/18 at 10:47 AM interviewed S16 to inquire about R19's Medicaid insurance coverage. According to S16, the resident had Medicaid insurance to cover ancillary charges and it covered PT. S16 stated that the emergency department (ED) clerks are in process of getting authorization, as pre-authorization for PT is obtained through Medicaid by ED clerks. Staff16 stated that S2 receives the Medicaid cards for eligible residents in the facility. On 05/30/18 interviewed S2 and inquired about R19's Medicaid insurance card and where in the process was the pre-authorization for PT services. S2 was not aware of R19's need for PT because the previous nurse manager handled those matters. S8 came to explain that the previous nurse manager told her that R19 did not have coverage for PT. Informed them that the business office staff told surveyor that R19 is covered by Medicaid for PT. S2 clarified with S16, and then stated that she would check with the ED clerks about the pre-authorization. On 05/31/18 at 08:27 AM S2 reported that R19 would be evaluated by PT today, as pre-authorization would take awhile. S2 stated	4 177	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. I.e. what program will be put into place to monitor the continued effectiveness of the systemic change(s). Quarterly therapy screening of all residents Effective date: July 20, 2018	

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4 177	Continued From page 30	4 177		

that the facility practice is to start PT/OT when awaiting preauthorization and didn't know why wasn't done for R19. On 05/31/18 at 08:39 AM observed R19 with PT at bedside being evaluated.

On 05/31/18 at 08:40 AM interviewed S11 and inquired where documentation can be found for PROM/ROM tasks. S11 accessed the EMR ADL flowsheet and from 5/28-30/2018 there was no documentation of R19 walking in hallway or receiving PROM/ROM exercises. According to S11, R19 received active ROM when assisted into his wheelchair and at meals because able to lift his arms, right leg and feed himself. S11 stated that R19 did walk from beginning of hallway to his room last weekend (Sat) but the staff probably didn't document. Upon further review of the ADL flowsheet found documented under, "Walk in Corridor Support" marked on dates 05/11-18/2018, and 05/29-30/2018. For all other dates it was checked - "ADL Activty itself did not occur during entire period." The "Ambulation Distance in Feet," documented a range of 40 - 125 feet on those dates. The "Range of Motion," to check "Passive or Active," was wholly left unchecked.

The care plan received for R19 developed on 11/30/17, " Plan - Provide Ambulation and Transfer Assistance DAILY Assist R19 ambulate with hemiwalker, Left AFO, left shoulder beace , and gait belt x 20-50' every day as tolerated to maintain functional mobility."

The EMR physician orders were, "Range of Motion: Passive ROM daily and q shft as requested. Daily; start 01/27/18 ordered by S35 on 01/26/18; Ambulate daily with hemiwalker with supervision."

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4 192	11-94.1-46(i) Pharmaceutical services (i) Appropriately licensed and trained staff shall be responsible for the entire act of medication administration, which entails removing an individual dose from a container properly labeled by a pharmacist or manufacturer (unit dose included), verifying the dosage with the physician's orders, giving the specified dose to the proper resident, and promptly recording the time, route, and dose given to the resident, and signing the record. Only a licensed nurse, physician, or other individual to whom the licensed professional has delegated the responsibility pursuant to chapter 16-89, subchapter 15, may administer medications. This Statute is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the medications were appropriately labeled in accordance with accepted professional standards and for the safe administration of medications for 1 of 5 residents (R3) in the sample observed for medication administration. Finding Includes: On 05/31/2018 at 08:39 AM, R3's med administration observation was done with S5. One of the medications S5 took out to administer were two Flonase (nasal) spray bottles. One Flonase bottle S5 scanned was labeled for use as Kenalog cream. At 08:53 AM, S5 stated the Flonase bottle with the Kenalog cream label on it did not scan to match the drug of order. S5 was asked if someone should have caught this since it was repeatedly used, and she said, "yes." She	4 192	4 192 Pharmaceutical services How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Pharmamerica started at KH on 6/1/2018 and all meds will be labeled by them. How the facility will identify other residents having the potential to be affected by the same deficient practice: Upon receipt all meds checked by RN to assure labels placed correctly. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. Upon receipt all meds checked by RN to assure labels placed correctly.	7/20/18

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4 192	Continued From page 32 confirmed it remained in the medication cart with no action taken. On 05/31/2018 at 03:08 PM, S2 acknowledged the Flonase was mislabeled.	4 192	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. I.e. what program will be put into place to monitor the continued effectiveness of the systemic change(s). All nurses will be observed by Pharmacist regarding safe med pass and checking labels prior to giving medications on a quarterly basis. Effective date: July 20, 2018.	
4 195	11-94.1-46(l) Pharmaceutical services (l) All drugs, including drugs that are stored in a refrigerator, shall be kept under lock and key, except when authorized personnel are in attendance. The facility shall be in compliance with all security requirements of federal and state laws as they relate to storerooms and pharmacies. This Statute is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the safe and secure storage of the medication carts used by the licensed staff during their medication administration to residents. Finding Includes: On 05/24/2018 at 01:35 PM, S29 left her medication (med) cart unattended in room 31 as she went to assist R11 who called out for help. During an interview with S29 afterward, she said the design of the med cart prevented the two	4 195	4 195 Pharmaceutical Services How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Lock placed on drawer June 6, 2018. How the facility will identify other residents having the potential to be affected by the same deficient practice: This is the only WOW designated for use for medication pass for KH.	7/20/18

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4 195	Continued From page 33 drawers to be locked/secured. On the afternoon of 5/24/2018, S1 verified that their current med carts could not be locked/secured. S1 stated it was due to their scanning system on the carts which did not allow the front drawers containing the residents' unit dose medications to be secured.	4 195	What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. RN educator to in-service all nurses regarding safe keeping medications. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. I.e. what program will be put into place to monitor the continued effectiveness of the systemic change(s). RN manager & designees will round on CAH WOW med pass to assure safe med pass and drawer locked before nurse walks away from the cart. Effective date: July 20, 2018.	
4 198	11-94.1-46(o) Pharmaceutical services (o) A pharmacist shall, on a monthly basis, review the record of all residents receiving medications to determine potential adverse reactions, interactions, and contraindications. The review and any concerns identified shall be documented in the resident's record. This Statute is not met as evidenced by: Based on record review and interview, the facility failed to ensure the drug regimen review of each resident must be reviewed at least once a month by a licensed pharmacist for 6 of 19 residents (R3, R4, R5, R10, R16 and R18) in the sample. Findings Include:	4 198	4 198 Pharmaceutical Services How corrective action will be accomplished for those residents found to have been affected by the deficient practice: New pharmacy service established. Pharmerica will perform monthly	6/6/18

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4 198	Continued From page 34 EMR review of R3, R4, R5 R10,R16 and R18 monthly drug regimen review (DRRs) found their April 2018 reviews were not done by the licensed pharmacist for each of these residents. During a concurrent review with S6 on 06/04/18 at 2:31 PM, he confirmed the DRRs were not done as found.	4 198	medication review. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents were affected. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. Pharmerica pharmacist will perform monthly medication review on all residents. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. I.e. what program will be put into place to monitor the continued effectiveness of the systemic change(s). Policy will be put into place of monthly medication reviews. It is already policy of Pharmerica that pharmacist perform monthly medication reviews on all residents. Effective date: 6/6/18	