Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	125003		06/22/2018

NAME OF PROVIDER OR SUPPLIER: KULA HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 100 KEOKEA PLACE, KULA, HI 96790

(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 State re-licensure survey was conducted from 6/19 - 6/22/2018. The resident census was 79.	4 000		
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure it has sufficient nursing staff in number and qualifications to meet the nursing needs of the residents for 11 of 24 residents (R56, R71, R31, R46, R75, R6, R39, R16, R30, R40 and R44) on one of the 4th floor nursing units. Findings Include: On 06/19/18 at 10:55 AM, R56 was found in the hallway yelling out loud that she wanted to go to the activity room. Even after two minutes of yelling, no staff attended to her. At 10:57 AM, surveyor approached S15 who was standing by a medication cart at the end of the hallway. S15 stated S90 had just brought R56 into the hallway after toileting her. However, the resident remained yelling while trying to push her wheelchair forward, but could not move. S90 then attended to the resident and wheeled her into the activity room.	4 148	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The deficiency identified in the survey of not providing adequate supervision to prevent accidents for R56, R71,R31, R46, R75, R6, R39, R16, R30, R40 and R44 was addressed: On 6/22/18 by increasing staffing to allow for 5 CNA (1st shift), 4 CNA (2nd shift), 3 CNA (3rd shift). This presents an increase of 1 CNA per shift. CNA specific assignments were developed on 7/10/18 to provide a minimum of 2 CNA's in the activity/dining room to provide appropriate supervision. Ensuring placement of residents in activity/dining room allows for staff to visualize the resident	7/20/18

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE

(X6) DATE: 07/13/18

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4 148	Continued From page 1 The nursing unit's census included 24 residents. On 06/19/18 at 11:28 AM, there were ten residents in the activity room. There was one certified nurse aide (S94) who was attending to R75 at the time. One resident, R6, was loudly mumbling words over and over and tried to reach out and grab other people while sitting at her table. R71 was observed touching the wall, touching the building blocks in front of her and/or sat trying to move her wheelchair around. S94 was not able to either calm or attend to these residents one to one, as they were spread out in two of the adjoining rooms. Then after the incident with R56 whereby she was found trying to insert the large building blocks into her mouth, S94 stated, "We only have one staff in here usually and it's really hard with just one staff." On 06/19/18 at 12:30 PM, during the lunch observation, it was found that R31 was able to feed herself. By 12:39 PM however, the spinach and beans were pushed toward the edge of her plate and ready to come off. The same observation was made earlier for R46 at 12:23 PM. R46 was using her left pointer finger to push her food onto her spoon so the food would not come off the edge of her plate. S15 observed this and concurred that these residents could benefit from a lipped or divided plate. No staff had observed R31 and R46's food coming off the edge of the plate as they were focused on delivering the meal trays to the residents and trying to feed those residents who needed closer monitoring and assistance. On 06/20/18 at 08:55 AM, observed R56 rocking back and forth in her wheelchair as if she wanted to move, but could not. R56 yelled out occasionally, and then quieted down. S97 said R56 rocks for comfort and liked to be by the	4 148	7/9/18 - Purchased and began use of hand-held radios for staff that will facilitate staff in the activity/dining room to communicate with other team members when there is a need for more staff in the activity/dining room. R31 and R46 assessed to determine if lipped or divided plate would be appropriate (7/11/18) □ implemented 7/13/2018 7/20/18 - (R56, R71, R31, R46, R75, R6, R39, R16, R30, R40 andR44) Development of activities directed toward residents that find it more challenging to participate in group activities in collaboration with Life Enrichment Coordinator and Managers. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents are at risk for the deficient practice of not providing adequate supervision to prevent accidents. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: On 6/22/18 by increasing staffing to allow for 1 additional CNA on all shifts.	

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4 148	Continued From page 2 window in the "low stim" room. However, during random observations of R56, she was often left alone with no meaningful activity. The "low stim" room however, was found to be a room where certain residents were left unsupervised because staff said it was to provide for a low stimulation environment. Yet, the observed outcome was that these residents (R56 and R39) were often left unattended with their needs not being assessed. At 09:07 AM, S97 stated in their activity room they had a lot of residents "with dementia. . .with behavioral." S97 expressed that it was really hard to monitor them. S97 said they separated the residents out, such that the TV room had six residents, the middle room had two residents and the other adjoining "low stim" room had two residents, including R56. S97 said due to her own health status, she would have to call for back-up help, which would then leave the floor staff short of one more aide. On 06/21/18 at 09:38 AM, S5 said they have one person to monitor the three adjoining activity rooms. S5 acknowledged their activity room floor plan did not allow for visibility from one side to the other because of the walls. S5 said some of their residents who were known to be "socially disruptive," made it difficult for only one staff to attend to all of these residents congregated in those rooms. S5 said because their unit had these "socially disruptive" residents, they were not brought up to attend the 5th floor group activities which residents of the other floors enjoyed. On 06/21/18 at 03:18 PM, an interview with S94 was done. S94 said often only about three of their residents attended the 5th floor large group activities. S94 said as soon as "they (the three	4 148	CNA specific assignments were developed on 7/10/18 to provide a minimum of 2 CNA's in the activity/dining room to provide appropriate supervision 7/10/18 - Ensuring placement of residents in activity/dining room allows for staff to visualize the resident 7/9/18 - Purchased and began use of hand-held radios for staff that will facilitate staff in the activity/dining room to communicate with other team members when there is a need for more staff in the activity/dining room. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Monitoring by unit manager to ensure adequate staff are available in the activity/dining room allow for all residents are appropriately supervised to assure resident safety, as well as for each resident to attain and maintain the highest practicable physical, mental ad psychosocial well-being. Reports of audits will be presented to QAPI (next meeting 7/26/18) for trending and actions taken.	

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4 148	Continued From page 3 4th floor residents) make noise" they were brought down to the 4th floor right away due to their behaviors. S94 said as a result, one staff on their unit "is always locked down to monitoring." S94 said although they may have four aides scheduled, only three aides could provide direct care since one person was assigned to the activity room to do unit activities with the residents. S94 said the unit activities were pretty much the same thing every day such as watching a DVD movie "for those who can," and going to the low stim room for others. Random observations found it was the same routine for the residents as S94 described, but without enough staff to oversee the care for the majority of the residents placed in the rooms. On 06/21/18 at 03:42 PM, R39 was observed in the "low stim" activity room sitting alone in a wheelchair. R39 kept saying, "Ah, ah, ah, ah, ah", both moaning and mumbling some illegible words. S51 was in the first large TV room assisting R16, and was unable to see R39. At 03:44 PM, S51 came into the low stim room from the hallway with R16 at her side. She saw R39 and said, "what's wrong papa?" but walked past R39, through the rooms and out into the hallway. R39's needs were not assessed as S51 did not attend to him with R16 at her side, nor did S51 ask for help. S51 walked into the low stim room again with R16, walked past R39 and had R16 sit at a table in the first room. At 03:48 PM, S51 was observed attending to R31 and to R71. R16 then tried to stand up and surveyor had to let S51 know what R16 was attempting to do. S51 quickly turned around as she was talking to R71, and said, "Oh, wait!" and then asked R16 if she wanted to walk again. At 03:51 PM, another aide came into the room; then a licensed staff at 03:52 PM. The staff however, were all situated in the	4 148		

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4 148	Continued From page 4 first room where R31, R6 and R16 were. The licensed staff then walked into the "low stim" room where R39 was, but turned around and walked back to the first room. At 03:54 PM, S51 came to R39's side to ask if he was okay. Yet, S51 and other staff failed to attend to R39's needs when he had been moaning and saying things. During an interview with S5 thereafter, S5 was queried whether there was sufficient staff to care for each resident in meeting their highest practicable well being on this unit. S5 said no, because of the type of engagement their residents required which was for more one to one interaction. S5 said their unit had residents with more behaviors, were more dependent and the cognitively lower functioning residents. On 06/22/18 at 07:29 AM, S94 said it was to a point where they were "burning out." S94 said their residents were often bypassed and not brought to attend the 5th floor activities. S94 acknowledged that safety too was a concern with just one staff monitoring 10 or more dependent residents with mood and behavioral issues. S94 said their staffing was decreased from five aides to four. S94 stated, "We're trying to provide activities, so actually our day shift has three aides for 24 residents since the assigned activity monitor (one of the four aides) cannot toilet the residents." S105 who was feeding R30 at this time, was observed trying to engage R30 during the meal, but had to also watch R16 because she would stand unassisted and unexpectedly. R40 was then seen pouring her orange juice (OJ) into her oatmeal. R71 sat in the middle room eating hurriedly out of her bowls, but S105 could not see	4 148		

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4 148	Continued From page 5 her from where she was sitting with R30 because of the side wall. S105 said, "it's difficult when you have (R16), (R40), (R44), (and another newly admitted resident) trying to stand all at once--it makes it hard." Observation of the breakfast found S105 trying to keep an eye out for the other residents around her while she was trying to assist and feed R30. But, S105 was not able to prevent R40 from pouring her OJ into the oatmeal, nor could S105 see R56 and R39. These two residents were sitting in their wheelchairs in the "low stim" activity room unattended and out of S105's view. On 06/22/18 at 07:45 AM, S5 stated their residents were those with advanced dementia with behaviors. S5 said approximately 15 of the 24 residents could be socially disruptive and/or physically/verbally aggressive during care. S5 said this made it hard for their unit staff and for new hires or floaters to work on this unit. S5 acknowledged because their residents were more dependent with ADLs (activities of daily living) and because of their behaviors, they were not included in the large group activities upstairs. S5 said given the needs of these residents, staffing for this unit "is not available." S5 concurred the way S105 had to feed R30 while "on edge" trying to keep an eye out for R16 and the rest of the residents was what their staff endured. S5 also acknowledged that although their fall rates have decreased, she concurred with the surveyor's observations that many of their residents were left unattended, without adequate supervision/engagement due to lack of staff coverage. S5 said it has been difficult to ensure their 14 residents who required assistance with meals and approximately 17 residents who	4 148		

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4 148	Continued From page 6 required extensive to total assistance in their ADLs received their highest quality of life as a result.	4 148		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation, interview and policy review, the facility failed to distribute food to residents in a sanitary manner. The deficient practice placed residents at risk for illness, infection and the potential for foodborne illness. Findings Include: During the lunch observation on 06/19/18 at 12:41 PM, Staff 36 (S36) was passing trays to the residents. S36 was observed to wipe his brow and touch his cheek on two occasions, and did not sanitize his hands before passing a tray to the next resident. S36 was observed to empty a tray into the refuse can and then passed another tray to a resident without sanitizing his hands. During an interview with S36 on 06/19/18 at 02:45	4 159	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The re-education and requirements for staff hand sanitation / hygiene will be practiced at all times, including the distribution of resident meal trays. This has been discussed with staff by resident unit manager 7/12/2018 HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE	7/13/18

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4 159	Continued From page 7 PM, he stated he didn't sanitize his hands after throwing food into the garbage or when he proceeded to get another resident's tray. S36 said, "I guess I had the white coat syndrome." Review of the Hand Hygiene policy 125-500-020 stated, "To reduce to as low as possible, the number of viable microorganisms on the hands in order to prevent transmission of healthcare associated pathogens from one patient to another, and to reduce the incidence of healthcare associated infections. . . 4. Before eating, after eating, . . ." S36 did not follow sanitary hand hygiene practices.	4 159	TAKEN: All residents are at risk for the deficient practice of not maintaining stringent sanitary distribution of meal trays to our residents. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: A staff re-education campaign was developed on July 11, 2018 and began the roll-out to staff on July 12, 2018. The education will be completed on 7/31/2018. The content of the education materials uses real-life examples and scenarios, in which staff must apply the practices of hand hygiene to assure the sanitary distribution of meals and maintain general infection control standards during care. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Beginning on 7/13/2018 - Direct observation of staff performing meal tray distribution will be done on each unit no less than twice weekly at varied meal times to assess for compliance. Observers will intervene when necessary and provide re-direction if needed to assure that appropriate practices are maintained. Several times a month the nursing managers will discuss their findings with the Director of Nursing. The nursing managers and Life Enrichment Coordinator will also report trended findings and actions taken at the monthly	

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4 159	Continued From page 8	4 159	QAPI meeting □ next scheduled 7/26/2018, - actions will be taken through enforcement and re-education as necessary to assure compliance with these requirements	
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure it maintained a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 2 of 24 residents (R56, R71) in the sample. Findings Include: On 06/19/18 at 11:18 AM, R56 was observed sitting at a table with oversized red Lego-type and wooden building blocks on it. The building blocks were being used by another resident, R71, who is blind. R56 had already grabbed one of the large red blocks and was trying to insert it into her mouth but it was too big. After licking it, she put it down on the table. She then grabbed a blue rectangular wooden block and tried to insert that large block into her mouth as well. S15 was in	4 203	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: 6/22/18 - Discussion of the need and expectation to provide adequate supervision of the use and sanitation of communal items such as the building blocks and lego-type items was done with staff by each of the resident unit managers. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents are at risk for the deficient practice of not maintaining a safe and sanitary environment to help prevent the	7/13/18

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4 203	Continued From page 9 the hallway and was asked to observe R56. S15 intervened and said R56 was not supposed to be handling these building blocks. The blocks were pushed toward R71 without being sanitized and R71 resumed using them. On 06/21/18 at 09:38 AM, S5 said they have one person to monitor the three adjoining activity rooms. S5 was informed of the observation whereby the blocks were not sanitized before it was given to R71, but had no comment. S94 said a lot had been going on that day when R56 tried to insert the blocks into her mouth. S94 said they usually wiped each block with the purple top disinfecting wipes and dried them for a couple minutes before putting them away. However, on 06/19/18 the blocks were not sanitized before they were returned to R71.	4 203	development and transmission of communicable diseases and infections WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: A staff re-education campaign was developed on July 12, 2018 and began the roll-out to staff on July 13, 2018. The education will be completed on 7/31/2018. The content of the education materials uses real-life examples and scenarios, in which staff must apply the practices assuring the sanitation of communal property between use than the requirement for the observation of their use. The adequacy of supervision of their use is also included in this education. 7/12/18 - An assessment of the use of such communal equipment was made by our Life Enrichment Coordinator and Nurse Unit Mangers □ adequate supplies or the items have been ordered along with soaking containers to allow a supply of items for use, while another set is soaking for sanitation. Staff education includes the proper soaking and drying time of the items between use. The additional sets of items and soaking containers are expected to arrive 7/16/2018 and be placed into use within three days of arrival to the facility. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Beginning 7/13/2018 - Direct observation	

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4 203	Continued From page 10	4 203	of resident use of communal items like the building blocks and their proper supervision and sanitation will be done on each unit no less than twice weekly at varied shifts times to assess for compliance. Observers will intervene when necessary and provide re-direction if needed to assure that appropriate practices are maintained. Several times a month the nursing managers will discuss their findings with the Director of Nursing. The nursing managers and Life Enrichment Coordinator will also report trended findings and actions taken at the monthly QAPI meeting (next 7/26/18), Actions will be taken through enforcement and re-education as necessary to assure compliance with these requirements	
4 218	11-94.1-55(e) Housekeeping (e) All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure the bedroom landing mats placed at the bedside was sanitary, safe and in good condition for 1 of 24 residents (R33). In addition, the facility failed to ensure the bathroom floor's black skid strips were in good condition for 1 of 24 residents (R56) and a dining room table was maintained in good, safe condition. Findings Include: 1) During the observation of Resident 33's (R33) bedside landing mat on 06/20/18 at 08:43 AM, it	4 218	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The items identified during the survey as deficient (landing mats, anti-skid strips and damaged table) were taken out of service at the time 6/22/2018. Anti-skid strip replacements were installed on 7/9/2018. Replacement landing mats have been ordered and have an estimated arrival date of 7/16/2018 and should be in	7/12/18

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NAME OF PROVIDER OR SUPPLIER: KULA HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 100 KEOKEA PLACE, KULA, HI 96790

(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
4 218	Continued From page 11 was found that both of the resident's beige colored landing mats had long cracks and tears throughout. As a result, some of the woven mesh underneath the beige cover could be seen. 2) During a bathroom observation 06/20/18 at 08:31 AM, it was found that R75's bathroom floor had large black skid strips that were peeled off and missing on four of the strips. 3) On 06/21/18 at 09:34 AM, during a concurrent room observation with Staff 5 (S5), she confirmed the beige floor mats for R33 were in disrepair, worn and torn. S5 said the mats needed to be replaced. S5 also concurred it did not present to be a safe and clean home environment, as there was a potential risk for falls due to the tears on the surface of the mats, and that the mats were potentially unsanitary due to the exposure of the woven material visible through the tears. 4) On 06/20/18 at 09:07 AM, R56 was observed holding onto the edge of a round table in the activity/dining room on 4 North. Portions of the table's white laminate type of siding were missing/torn off, leaving an uneven surface that could potentially affect (poke or scratch) one's skin. R56 gripped onto the side where the missing laminate was and used her hands to push and pull her wheelchair back and forth. No staff was present to observe her. On 06/21/18 at 09:52 AM, a concurrent observation of the activity/dining room on 4 North was done with S5. S5 verified there were portions of white siding missing on the table's edge. S5 said she did not want anything to cause injury to the residents and maintenance would be notified.	4 218	service 7/18/2018 HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents are at risk for the deficient practice of not maintaining the physical environment in a good repair and clean. A further review of landing mats, anti-skid strips, and activity surfaces within resident care areas was completed on 7/5/2018. Items that were identified as not in good repair and clean were taken out of service at that time. Replacement landing mats and anti-skid rugs were placed into service on the 2nd/3rd /5th floors by 7/10/2018. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: A larger facility assessment of larger items such as furniture was completed on 7/12/2018. The findings of the assessment are being reviewed and prioritized. Focus will be made on new purchases of furniture that support 1) our ability to maintain surface cleanliness, 2) durability, 3) opportunity for our residents to engage in social engagement with one another, and 4) maximize the physical space limitations of our rooms to provide line of sight supervision for resident safety. Item selections will be made involving our resident council, along with nursing /	

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4 218	Continued From page 12	4 218	activities staffs and reported at our next QAPI meeting 7/26/18 HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Beginning July 12, 2018 - Monthly environmental rounds by our Director of Nursing, Department Manager, and Housekeeping will be performed in our resident care areas. Items identified to be addressed will be scheduled for remediation and management will monitor for timely completion. Results of the environmental rounds will be reported at the monthly QAPI meeting (next 7/26/2018) to assure that they are completed and provide awareness of the facility condition to assure proper long-term planning for larger renovation needs. Resident council input on furniture selection will be reported and thereafter at the next QAPI meeting and the ordering process will begin thereafter.	