STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125026	A. BUILDING: _____ B. WING _____	09/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUAKINI GERIATRIC CARE, INC	347 NORTH KUAKINI STREET HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	Initial Comments A recertification survey was conducted September 11-14, 2018. The census on admission to the facility was 170. The facility is licensed for 187. A complaint investigation (HI00005579) was included in this survey and substantiated and cited at F 725 and F 925.	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 medical care with listing of physicians providing care, recent physical examination, tuberculosis status, and physician's orders; and	4 101		11/13/18

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4 101	Continued From page 1 (8) Advanced directives, as applicable. This Statute is not met as evidenced by: Based on record review and interview, four residents (R)159, 148, 62 and 50 did not have an advanced directive and did not receive additional information about advanced directives during admission to the facility. Findings include: 1) During review of the record, the status of advance directive form is checked number 2 indicating resident does not have an advance directive. The box on the following line is left unchecked that indicates resident/ family given information about advance directive by social service. During an interview on 09/13/18 at 03:47 PM with the 6th floor patient care coordinator who stated it is the social worker who meets with the family/ representative to give them the information about advance directives. During an interview with the Director of Nursing (DON) on 09/13/18 at 03:49 PM who concurred that the SW will provide the information on advanced directives to the family during the admission/ intake process. 2) On 09/12/18 at 07:53 AM, review of R148's record reflected that "Status of Advanced Directive" indicated "POLST in file", signed and dated 08/20/18. The POLST is not an advanced directive. No advanced directive in the record.	4 101	Corrective Action for Resident Affected: * Social Worker will provide a verbal and written notice to Residents #159, #62, and #50 and their families on the right to formulate an advance directive. This will be documented in the Social Work section of the chart as well as on the form, Status of Advance Directive. Completed 11/11/2018 * Resident #148 was discharged on 09/27/2018. No action was taken due to discharge of resident. How Facility will ID other residents having the potential to be affected by same defective practice: * Social Worker or designee will complete a 100% audit of all resident charts for advance directives documentation. Social Worker will follow-up with the residents who do not have advance directives documentation in their chart. The discussion on advance directives and each resident□s preferences will be documented in the respective resident□s chart. Completed 11/11/2018 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: * RN screener for new admissions to KGC will ask for additional documentation	

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4 101	Continued From page 2 On 09/14/18 at 08:29 AM, interview with Patient Care Coordinator(PCC)1 validated that R148 did not have advanced directive or there was no evidence that resident or resident's representative was informed of their right to formulate an advanced directive. 3) During a record review of Resident (R) 62, there was no Advance Health Care Directive (AHCD) in place. There were also no other forms or notes in the chart that would indicate if follow up was done. After staff interview with Social Work (SW) 1, on 09/13/18 at 10:06 AM, SW1 stated that follow up on AHCD usually takes place during quarterly Interdisciplinary Team (IDT) meetings. However, for this resident, SW1 acknowledged that no AHCD follow up was done. A review of facility policy titled Patient Self-Determination Act/Advance Directives, states that if a resident has not executed an AHCD a referral to SW will be made in the event the resident request a AHCD follow up. Again, there was no follow up. 4) During a record review of Resident (R) 50, there was a form titled Status of Advanced Directive (AD) which stated the resident/family declined assistance; dated 11/06/15. Further record review showed IDT meeting notes; dated 07/16/18, section on AD was not checked. This meant that further follow up on AD was not performed.	4 101	on whether the patient has had a discussion with a Social Worker regarding advance directives. If the patient has not had a discussion, RN screener will request that a KGC Social Worker be notified upon the patient□s admission to KGC. Completed 11/10/2018 and ongoing * Social Worker will conduct follow-up audits on 100% of patients admitted to KGC within 5 days of admission. If discussion on advance directives has not been documented, Social Worker will have the discussion with the resident within 2 working days of discovery of the missing advance directive. Completed 11/11/2018 * Mandatory in-service will be completed for all licensed staff on advance directives requirements, its importance, and the difference between a POLST and an Advance Directive. Completed 11/13/2018 and ongoing How the Facility will monitor its corrective actions to ensure that the deficient practice will not recur: * Social Worker or designee will report results of random audits to KGC Nursing Management at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings. Completed 11/11/2018 and ongoing.	

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4 148	Continued From page 3	4 148		
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: State Agency (SA) received Complaint(C)5579 and was investigated during this survey. Based on record reviews, staff interviews, family interviews and policy and procedures, SA concluded the facility did not provide nursing services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being. Findings include: 1) An anonymous complaint was made to the SA. Complainant stated that there was a shortage of nursing staff on all shifts on the 4th floor of the Long-Term care unit. Complainant stated her mother who is a resident there would call for help and it takes staff 20-30 minutes or more to answer her call. Complainant further stated that she noticed staffing shortage for the past year and it is still on going and is the reason why she called. Interview with Registered Nurse (RN)1 on 09/11/18 at 10:00 AM who states they have no manager now for one year. RN1 is the charge nurse, acting manager at times and does the	4 148	Corrective Action for Resident Affected: Staffing: * Ongoing staff recruitment and hiring efforts include the following: o Additional 5 Nurse Aides, 1 LPN, and 1 RN have been hired. Completed 10/01/2018 o 12 RN (casual part-time) positions were created and 8 positions have been filled. Completed 09/17/2018 and ongoing o External staffing agency contract for 6 CNA positions were approved and currently being recruited. Completed 11/12/2018 and ongoing o KGC management attended the Kapiolani Community College (KCC) job fair to recruit applicants from the graduating CNA class. Follow-up is being done on the additional referrals received from the KCC job fair. Completed 10/12/2018 and ongoing o Patient Care Coordinator (PCC) for ICF4 was hired. Completed 10/14/2018	11/13/18

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4 148	Continued From page 4 Minimum Data Set (MDS) assessments. Observation made on 09/11/18 at 01:00 PM. Seven residents sitting in wheelchairs surrounding the nurses station in an L-shape. One resident in a wheelchair is calling for help and stands up. Resident is attached to a large oxygen tank. This surveyor alerted the unit clerk (UC) and the UC attends to her. Observation made on 09/12/18 at 12:37 PM. Six residents sitting in wheelchairs surrounding the nurses station in an L-shape. The UC keeps an eye on residents and talks with them and attends to their questions and assists them if needed. UC tends to ancillary staff that approach with questions, telephone calls and residents in the wheelchairs. Interview on 09/13/18 at 0810 AM with Resident (R)165. R165 stated that he had concerns about finances resulting in significant understaffing. "It's detrimental to the patients. Everyone is rushed here. The staff is doing their best they can. If they are in a procedure, we have to wait until the next person or next shift. I've had someone who was feeding me with the tube feeding and had to leave before pouring the feeding in. They just don't have enough people. On occasion, when I begin to regurgitate and I come up with phlegm and I'm not spitting it up, it could go back down." Interview on 09/14/18 at 0200 PM with R423 who stated that "I wait sometimes an hour or more to brush my teeth. I needed someone to pull me up, I tried but I couldn't. I sit day in and day out in this bed." Interview with Unit Clerk (UC)1. The daily assignment sheet showed CNA3 written down as	4 148	* Additional staff positions were approved for recruitment. Job descriptions will be completed for new positions of bath aide and feeding aide. Analysis of staffing needs and personnel request by resident unit will be completed. Completed 11/13/2018 and ongoing * All KGC management are assigned to specific resident units when all hands on deck procedure is activated. This procedure requires all KGC management to deploy to their assigned resident units during the residents□ lunchtime to assist with the passing of meal trays and helping residents with meals. Completed 09/17/2018 BIMS: * Brief Interviews for Mental Status (BIMS) will be completed with Residents #78, #99, and #100 with additional Minimum Data Set (MDS) Section C documentation. If indicated by the Care Area Assessment (CAA), the respective resident□s Care Plan will be developed or revised. Completed 11/11/2018 * Resident #50 was discharged on 9/27/2018; therefore, no action was taken. How Facility will ID other residents having the potential to be affected by same defective practice: Staffing: * Analysis of staffing needs and personnel request by resident unit will be completed. Completed 11/13/2018 and ongoing	

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4 148	Continued From page 5 scheduled; however, UC1 says "she is not here." It was clarified that although, the name of CNA3 appeared on the daily assignment sheet as present, the name was not lined out as if to show CNA3 was not on the floor, therefore leaving confusion in the actual assignment of ICF-4. UC1 stated we have CNA2 who is from another floor. When asked about how many CNAs are supposed to be on floor, she stated about four. When asked if they are short staffed, she said "you have to talk with them downstairs". (refer F812). Record reviews (RR) on 09/13/18. Kuakini Staffing Matrix was obtained. Daily assignment sheets for ICF-4 for the month of August and September 01 through September 12, 2018. The census during this survey dates of September 11, 2018 through September 14, 2018 was approximately 46-48. According to the staffing matrix for ICF residents with a census of 46-48, staffing should be as below: Staffing grid consists of: (Registered nurse (RN), Licensed practical nurse (LPN), and Clinical nurses assistant (CNA). Days RN - 1, LPN - 2 and CNAs - 5 Eves RN - 0, LPN - 2 and CNAs - 4 Nights RN 0, LPN - 1 and CNAs - 3 RR of Daily assignment sheets for the month of August revealed that 28 days out of 31 days, ICF-4 was short-staffed and 10 days out of 12 days in September ICF-4 was short-staffed. This meant that either they were short a Registered nurse, licensed nurse or CNA and a lot of times a combination shortage of a nurse and CNA. Interview on 09/14/18 at 02:30 PM with DON and Administrator. Administrator stated "We have	4 148	BIMS: * RN with MDS knowledge will audit all ICF charts for completion of BIMS in MDS, date of initial cognitive assessment, and completion of Section C in MDS. Completed 11/11/2018 * Residents who do not have a completed BIMS will have assessments completed and/or revised and a Care Plan developed or revised regarding the residents cognitive level and status from assessment to assessment. Completed 11/11/2018 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staffing: * Patient Care Coordinator (PCC) will monitor and track daily staffing by resident unit to meet staffing and safety needs. Completed 09/17/2018 and ongoing * KGC management will develop a monitoring system that includes trending of the daily staffing tracking by resident unit. Completed 09/17/2018 * KGC management will review the data from the monitoring system and develop a plan for safe staffing. Completed 09/17/2018 and ongoing * Kuakini Staffing Services will contact all KGC employees for voluntary overtime and external staffing agencies for additional contract staff based on staffing needs. Completed 09/17/2018 and ongoing	

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4 148	Continued From page 6 been trying to advertise the position on the website. We are talking about it with friends. One of our major things we have done is go through senior administration and cross train these RNs from the acute hospital. They have to apply and be trained on this side. It took us a long time to negotiate because of the Hawaii Nursing Association (HNA). Five RNs are on board and the last three are going through orientation. We staff heavily with agency. We have four contracted LPNs from the mainland. One LPN stopped last week. The contracted LPNs are all on a three-month contract. We also have been processing other applications. We are expecting a new shift coordinator on board. We had a new CNA who resigned, and we worked with her to rearrange her schedule, so she would not leave. We have three new CNA applications per administration. 2) On 09/11/18 at 11:20 AM resident lunches were delivered to the fourth-floor unit. During this lunch observation it was noted that there were only two Registered Nurses (RNs) and two Clinical Nurses Assistant (CNA) working with the 45 residents on the unit. Followed RN1 and CNA3 to observe meal delivery and time last tray was delivered to resident who required assistance from staff. Inquired of CNA3 the meal tray delivery routine for the unit and she stated first staff deliver the meal trays to the residents in their rooms who do not require assistance from staff, next they deliver meal tray to residents in the solarium and then to residents in their rooms who require assistance with their meals. Inquired of RN1 how many residents on fourth floor unit require assistance at meal times and he identified 11 residents (R9, 46, 47, 51, 80, 81, 102, 104, 118, 119, and 166). Lunch meals were delivered to residents in their rooms and the solarium from	4 148	* KGC Administration may limit admissions to SNF and ICF based on available staffing. Completed 09/17/2018 and ongoing BIMS: * All licensed staff responsible for completing MDS assessments on ICF residents will be re-educated on the correct completion of cognitive assessments. Completed 11/11/2018 and ongoing * RN designated to complete the BIMS in the MDS on the due date will notify the Patient Care Coordinator (PCC) for additional assistance, if needed. Completed 11/11/2018 and ongoing * Designated RN who transmits ICF MDS document to Centers for Medicare and Medicaid Services (CMS) will review each MDS for completion of all sections including the presence and accuracy of the Care Plan listing cognitive status from assessment to assessment. Completed 11/11/2018 and ongoing How the Facility will monitor its corrective actions to ensure that the deficient practice will not recur: Staffing: * KGC management will report the findings from the monitoring system that includes the trending of the daily staffing tracking by resident unit at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings. Completed	

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4 148	Continued From page 7 11:30 AM - 11:55 AM. First meal observed delivered to R118 at noon by CNA3. At 12:05 PM RN1 took a meal tray to R166 in the room and assisted the resident. At 1210 CNA3 took a meal tray to R102 and assisted the resident in the room. At 12:38 PM CNA3 took a meal tray to R102 and assisted the resident in their room. The last lunch tray was delivered by CNA2 at 12:55 PM to R51 and she assisted the resident in their room. Last meal tray was delivered to the resident an hour and 35 minutes after the meal trays were delivered to the unit. Staff assigned to work on fourth floor unit were the only staff delivering meal trays and assisting residents with their meals. It was noted that the unit that day was short an LPN and 3 CNAs per the facility's staffing matrix. The deficient practice puts all the residents on the fourth floor at risk for weight loss and significantly affects the resident's quality of life, with possibility of causing them to experience depression when presented with a late meal which may not be appealing to the resident who has waited a long time for staff to assist them with their meal. Cross reference to F641 3) On 09/11/18 during initial assessment of resident (R) 50, 78, 99 and 100 on fourth floor it was noted that the residents were missing Brief Interview for Mental Status (BIMS) scores in section C of the (Minimum Data Set) MDS assessments. On 09/11/18 at 02:17 PM interviewed Registered Nurse (RN) 1 and inquired why some residents on the fourth floor did not have complete BIMS assessments in their MDS assessments and he stated that if he did the MDS assessment on a	4 148	11/11/2018 and ongoing BIMS: * PCC or designee will complete monthly chart audits on all resident admissions and quarterly MDS to ensure completion of all sections. Completed 11/10/2018 and ongoing * PCC will report their monthly chart audit results to KGC Nursing Management at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings. Completed 11/11/2018 and ongoing	

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4 148	Continued From page 8 day where he is passing medications "it is too hard" and he "does not have time," he stated he had been told that it was ok not to do that section. It was noted that on 09/11/18 there were 45 residents on the unit with two RNs and two CNA working. The facility's staffing matrix shows that there should have been one RN, two Licensed Practical Nurses (LPN) and 5 CNAs. This shift only had half of the staff that the facility's staffing matrix called for. On 09/13/18 Record review of R50, 78, 99 and 100 MDS Section B Hearing, Speech, and Vision was coded for these residents as not in a persistent vegetative state, had adequate hearing, did not use a hearing aid, had clear speech, are able to make themselves understood and can understand others. R50, 78, 99 and 100 were physically able to participate in a BIMS assessment during their last look back period. Review of R50, 78, 99 and 100 MDS section C Cognitive Patterns found all these residents last quarterly or annual assessments incomplete. This deficient practice puts all the residents in the facility at risk for incomplete mental status assessments, making it impossible to determine if the resident has had an improvement or decline in their mental status. 4) During an interview with family member (FM)96, on 09/11/18 at 02:13 PM who stated one of the biggest concerns is under-staffing. I come here every day to deliver the paper. FM96's mother-in-law tells FM96 that it takes so long to get any help. FM96 said he attends the family forum and has asked several times what is being done about the short staffing and is always told the same thing that they're working on it. FM96's mother in law has been here for three years.	4 148		

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4 148	Continued From page 9 FM96 said that other families have brought up the same issue at the family forum and some have privately hired individuals to come in to help their family members. FM96 said that sometimes the food is also late, and cold. FM96 has told me that on a few occasions his mother-in-law told him that she couldn't eat the saimin (a noodle dish served hot) because it was too cold. During an interview on 09/12/18 at 05:17 PM with FM136, who stated staffing is terrible here. There used to be five Clinical Nurses Assistant, (CNA's) now we only see a few. They work so hard. We started a petition to start a family forum to address staffing concerns and I finally gave up and quit going to the meetings. It seems like they hold steady on the eve shift but on the day shift it is the worst. The call lights are going off constantly and for a long time. During an interview with R96, 09/12/18 10:30 AM who stated that there aren't enough staff here, there just aren't enough. I always have to wait to use the bathroom I can see they are so busy. During an interview with an anonymous licensed staff member on 9/13/18 at 12:45 PM, who stated we really need five Clinical Nurses Assistant on this floor, but that rarely happens. On 09/13/18 at 08:45 AM observed R96 sitting up in wheelchair at the nurses' station. she stated to the surveyor. Yesterday when I spoke to you I meant that there aren't enough staff here to take care of the other residents, sometimes the CNA's have as many as 15 or 20 residents to take care of, that's just not enough. When we return from activities and sit up here waiting at the nurses' station to go to our rooms we really need to use the bathroom, it would be great to have enough	4 148		

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4 148	Continued From page 10 staff to take us as soon as we get back, it's just not enough.	4 148		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on resident observation, record review (RR), family member (F)1 and staff interview the facility failed to develop and implement a care plan (CP) for resident (R) 58's bed rail use for bed mobility, and for Resident (R)118's bed rail use for bed mobility, to attend activities and chest pain.	4 149	Corrective Action for Residents Affected: * Resident #58 - Care Plan will be developed for bed rail use for bed mobility. Completed 09/15/2018 * Resident #118 □ The following Care Plans will be developed:	11/12/18

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4 149	Continued From page 11 Findings Include: 1) On 09/11/18 at 10:00 PM R58's bed was observed with bilateral upper half side rails. R58 was admitted to the facility on 06/29/18 and had the following diagnosis cerebrovascular accident (CVA) with right sided weakness, history of transient ischemic attack (TIA), paroxysmal atrial fibrillation, hypertension, dementia, Diabetes Mellitus (DM) type 1, depression and glaucoma. On 09/14/18 at 12:35 PM during RR found that R58 has a Bed Rail assessment completed on 06/29/18 and had the informed consent for bed rail use. Noted on the Bed Rail Assessment that R58 has a history of right sided weakness and history of CVA and it was checked that R58 "demonstrates using the bed rail or other device to assist in bed mobility, postural support, or transfers during ADL self-care." During RR of R58's CP it was noted that there was no CP for bed rail use for bed mobility. Interviewed Licensed Practical Nurse (LPN) 1 who confirmed that R58 did not have a CP for bed rail use for bed mobility and that she should have had a CP. 2) On 09/11/18 at 10:41 PM R118 was observed sitting up in his bed watching TV. Later in the day R118 was observed eating his lunch, in his room, in his bed with staff at his bedside assisting. On 09/12/18 at 09:25 AM during family interview with R118's F1 inquired if R118 attends activities at the facility and they stated that R118 "goes to activity with staff who push him in his wheelchair." On 09/12/18 at 09:36 AM during family interview with R118's F1 inquired if R118 has pain and she stated R118 "complained of chest pain twice this	4 149	o Care Plan will be developed for bed rail use for bed mobility and for attending activities while in a wheelchair. Completed 09/15/2018 o Care Plan will be developed for chest pain related to atrial fibrillation and hypertension. Completed 09/15/2018 How Facility will ID other residents having the potential to be affected by same defective practice: * Patient Care Coordinator (PCC) and Charge Nurses will complete a chart audit of all residents utilizing bed rails for appropriate bed rail use and presence of individualized Care Plan for bed mobility based on the resident□s condition and preferences. Completed 11/11/2018 * PCC and Charge Nurses will complete an audit of resident charts for comprehensive person-centered Care Plans including chest pain and hypertension based on the resident□s condition and preferences. Completed 11/11/2018 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: * All licensed and non-licensed staff will attend mandatory in-service training regarding person-centered care and developing comprehensive Care Plans to address a resident□s unique condition (which includes chest pain and hypertension) and preferences which must be included in the resident□s Care Plan. Completed 11/12/2018 and ongoing	

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4 149	Continued From page 12 year and this goes away when he takes his medicine." Inquired when this occurred and F1 stated " this occurred last month." F1 was unable to state the name of medication that R118 takes to alleviate his chest pain. On 09/12/18 at 12:17 PM R118 was observed in his bed with bilateral upper half side rails up on his bed. R118 was admitted to the facility on 05/17/18 and had the following diagnosis cerebrovascular accident (CVA) with left hemiplegia, atrial fibrillation, hypertension, hyperlipidemia, dementia, and dysphagia. On 09/14/18 at 02:43 PM RR found that R118 had a Bed Rail assessment dated 08/20/18 for top bed rails completed quarterly and informed consent for bed rails dated 08/10/18 which R118 signed. Reviewed R118's CP and did not find bed rail use for bed mobility and activities care planned for. Interviewed LPN1 who confirmed that R118 did not have a CP in place for bed rail use for bed mobility or activities and that these should have been on R118's CP. On 09/14/18 at 03:18 PM RR found that R118 had three documented incidents of chest pain on 08/07/18, 08/30/18 and 09/03/18. Medical Doctor (MD) was notified on 08/07/18 of R118 having chest pain and no orders were given. Each time R118 complained of chest pain this was documented by a nurse, the MD was notified, the pain subsided and was monitored by the nurse. LPN1 confirmed this with progress notes in R118's medical chart. LPN1 confirmed that R118 did not have a CP for chest pain and that he should have had one. Review of facility policy "Interdisciplinary Care Management Process" found "2. Interdisciplinary	4 149	* PCCs or designee will complete monthly chart audits on all residents utilizing bed rails and monitor for 100% compliance with documentation requirements on bed rail use. Completed 11/10/2018 and ongoing * PCCs or designee will complete monthly chart audits on the interdisciplinary Care Plans and monitor for 100% compliance with documentation requirements on bed rail use for bed mobility based on the resident□s condition and preference. Completed 11/10/2018 and ongoing How the Facility will monitor its corrective actions to ensure that the deficient practice will not recur: * PCCs will report monthly chart audit results to KGC Nursing Management at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings. Completed 11/10/2018 and ongoing	

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4 149	Continued From page 13 Plan of Care: ... f. Roles and Responsibilities of the interdisciplinary team i. Nursing Addresses triggered Care Areas for all sections of the MDS, except those as outlined below, and develops the appropriate care plans with input from the interdisciplinary team. ... Presents and discusses the nursing treatment plan for the resident, including but not limited to the following: 1) Safety and accident prevention 2) Restraint use 3) Skin condition and integrity maintenance 4) Pain management 5) Psychotropic medication use 6) Any other pertinent clinical issues."	4 149		
4 160	11-94.1-41(b) Storage and handling of food (b) Effective procedures to promptly and consistently clean all equipment and work areas shall be enforced. This Statute is not met as evidenced by: Based on staff interviews, observation and policy and procedure, the facility failed to distribute and serve food in accordance with professional standards for food service safety. Based on observation during initial tour of the facility kitchen the facility tested their sanitizing solution test strips with expired testing strips. This deficient practice had the potential to affect the whole facility, putting the 155 residents at risk for foodborne illness. Findings Include: 1) On 09/11/18 at 11:43 PM during a lunch observation, RN1 observed staff passing trays without Handwashing (HW) and/or Hand Sanitizing (HS). Between pushing the lunch cart	4 160	Corrective Action for Resident Affected: * All nursing staff will be re-educated on proper hand hygiene when passing meal trays. Completed 11/09/2018 and ongoing * Dietary staff will test the sanitizing solution utilizing non-expired Hydrion QT-10 testing strips. Completed 09/11/2018 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: * Dietary Service Supervisors and Dietary staff will be educated that test strips have an expiration date, shown where the expiration date is located, and	11/15/18

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4 160	Continued From page 14 to the solarium and passing trays between residents, there was no HW or HS performed. The other staff assisting with passing trays was Clinical Nursing Assistant (CNA)1. After passing trays to two rooms, there was no HS done. At 11:49, CNA1 washed her hands after passing trays to rooms. Interview on 09/11/18 at 12:00 PM with CNA1 - explained to CNA1, this surveyor's observation during dining and that she did not perform hand hygiene (HH) before and after assisting a resident with meals and pushing cart to solarium from hall and then passing tray from cart to two residents without HH. CNA stated "We are short staffed. Supposed to be 4 or five CNAs but we only have two." Record Review (RR) P&P obtained for HH - page 2, number 2, letter b - Alcohol based hand rubs are not an acceptable means of hand hygiene in the following situations. Hands are to be washed with antimicrobial soap and water. (c) Before and after assisting a resident with meals. Interview with Unit Clerk (UC)1. Daily assignment sheet which showed CN3 scheduled; however, UC1 says "she is not here." UC1 said, "We have CNA2 who is from another floor." When asked about how many CNAs are supposed to be on floor, UC1 stated about four. When asked if they are short staffed, UC1 said "you have to talk with them downstairs." 2) On 09/11/18 at 08:27 AM during initial tour of the kitchen with the kitchen manager and kitchen supervisor we passed the sanitizing sink that was	4 160	to check the expiration date before new tape is issued to ensure that the tape is not expired. Completed 09/13/18 * KGC Hand-Hygiene Policy No: 01-06-11 will be reviewed and revised to include current infection control standards. Completed 11/11/2018 * All KGC nursing staff will be in-serviced on the current infection control standards in the revised Hand-Hygiene policy. Completed 11/12/2018 How the Facility will monitor its corrective actions to ensure that the deficient practice will not recur: * Patient Care Coordinator (PCC) or designee will conduct weekly random observation audits during meal service to ensure that proper hand hygiene protocol is being followed. Completed 11/12/2018 and ongoing * PCCs will report the weekly random audit results to KGC Nursing Management at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings. Completed 11/15/2018 and ongoing * Dietary Services will develop a log to record the date that the new test tape is issued, the test tape□s expiration date, Supervisor□s name, and signature. All Dietary Service Supervisors will be informed of the new log and procedures. Completed 11/08/2018 * Dietary Manager will audit logs on a monthly basis for compliance and report results to KGC Nursing Management at the monthly Interdisciplinary Team (IDT)	

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4 160	Continued From page 15 filled with water and sanitizing solution. Kitchen supervisor was asked to test the sanitizing solution. Kitchen supervisor tore off a piece of Hydrion QT-10 testing strip and submerged the testing strip for approximately 20 seconds. Kitchen supervisor then compared the test strip to the legend on the test strip package. The test strip matched the 200 parts per million (ppm) color on the legend. After this was done it was noted that the Hydrion QT-10 testing strip was outdated with an expiration date of "Oct. 15, 2017." Kitchen manager stated that she was not aware that the testing strips had an expiration date. On 09/13/18 at 04:50 PM kitchen manager stated that on 09/11/18 the kitchen staff were able to retrieve a packet of testing strips from the hospital cafeteria kitchen and tested the sanitizing solution and this also registered at 200 ppm.	4 160	meetings and at the quarterly Performance Improvement Committee meetings. Completed 11/15/2018 and ongoing	
4 269	11-94.1-65(d)(6) Construction requirements (d) The facility shall have adequate toilet and bath facilities: (6) An adequate supply of potable running water shall be provided at all times. Temperatures of hot water at plumbing fixtures used by the residents shall be automatically regulated and shall not be below 100 or above 120 degrees Fahrenheit; This Statute is not met as evidenced by: Based on observation, staff interview and record review the facility failed to maintain safe water temperatures ranging from 100 to 120 degrees Fahrenheit facility wide placing the residents are	4 269	Corrective Action for Resident Affected: * Maintenance will complete temperature (temp) adjustments on the	11/15/18

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4 269	Continued From page 16 risk for burns. This deficient practice had the potential to affect the 155 residents at the facility. Findings Include On 09/11/18 during initial walk through of the fourth-floor unit it was noted the water in the resident's room sinks were very hot to the touch when the hot water was turned on. At 04:15 PM met with maintenance staff (MS)1 to test water temperatures in the resident's rooms. Tested rooms 404, 419, 420 and 423 and found water in room 419 was 122.3 degrees Fahrenheit using a digital thermometer. Rooms 404, 420 and 423 water temperature range were from 112.8 degrees Fahrenheit to 120 degrees Fahrenheit. On 09/12/18 at 11:10 AM met with facility maintenance manager to discuss spot checks of hot water temperatures and he showed his Daily Hot Water Temp Log from 06/01/18 - 09/10/18. Review of the log found hot water temperatures ranging from 112-127 degrees Fahrenheit. Facility maintenance manager was reminded that facility was cited last year for exceeding the safe hot water temperature as the facility's water temperature was also recorded above 120 degrees Fahrenheit during the 2017 survey. Inquired what was done with the room sinks that went over 120 degrees Fahrenheit on the logs that he shared with me, facility maintenance manager stated that his boss quit last month and that his boss was responsible for that part of the plan of correction. Upon observation, staff interview and review of hot water logs found the facility failed to maintain resident's hot water temperatures between 100-120 degrees Fahrenheit even after having been cited the previous year for this. This	4 269	KGC Heat Pump to ensure that the hot water temps for the KGC facility are within the 100¿ to 120¿ range. Completed 10/22/2018. How Facility will ID other residents having the potential to be affected by same defective practice: * Boilerman from Maintenance Department will conduct hourly checks on all of the utilities in the KGC facility including the logging of outgoing hot water temps from the hot water system. Boilerman will measure water temps in different resident□s rooms in the morning and in the evening to ensure that the hot water temps are within the 100¿ to 120¿ range. If the hot water temp is out of range in the resident□s room, adjustments to the temperature will be made and documented; and the hot water temp will be re-tested and documented to ensure the hot water temp is within the allowable range. Completed 10/22/2018 and ongoing. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: * Maintenance Department staff will utilize only one type of thermometer for checking the hot water temps on each resident unit in order to ensure consistent temperature readings. Adjustments will be made for hot water temps outside of the 100¿ to 120¿ range, re-tested, and documented. Completed 10/22/2018 and ongoing.	

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4 269	Continued From page 17 deficient practice puts the 155 vulnerable residents at risk for burns as the elderly residents' skin are thinner, some of the residents are mute and unable to state that the water is too hot and 80 of the 155 residents have been identified with dementia on the facility matrix and might not be able to communicate to staff that the water is too hot or that they have hurt themselves with the hot water.	4 269	How the Facility will monitor its corrective actions to ensure that the deficient practice will not recur: * Maintenance Department Manager or designee will review the hot water temperature logs which reflect the hot water temp readings on a daily basis to ensure that the hot water temps are within the 100¿ to 120¿ range. If the hot water temps are out of range, the person in charge or designee will make adjustments to the temperature as needed and will re-test and document the hot water temp readings. Completed 10/22/2018 and ongoing * Maintenance Manager or designee will review the hot water temperature logs for compliance and report results to KGC Nursing Management at the monthly Interdisciplinary Team (IDT) meetings and at the quarterly Performance Improvement Committee meetings. Completed 11/15/2018 and ongoing	