Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	125002		11/16/2018

NAME OF PROVIDER OR SUPPLIER: HILO MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 1190 WAIANUENUE AVENUE, HILO, HI 96720

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4 000	Initial Comments A relicensing survey was conducted by the Office of Health Care Assurance on 11/13/18 through 11/16/18. The census was 36 upon entrance.	4 000		
4 105	11-94.1-22(g) Medical record system (g) All entries in a resident's record shall be: (1) Accurate and complete; (2) Legible and typed or written in black or blue ink; (3) Dated; (4) Authenticated by signature and title of the individual making the entry; and (5) Written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical doctor. This Statute is not met as evidenced by: Based on record review, staff interview, and policy review, the facility failed to accurately document the dates on a Physician Orders for Life-Sustaining Treatment (POLST) form for Resident (R) 23. As a result of this deficient practice, the POLST form would be invalid, and R23 may not have received the care as indicated on the prepared POLST form. Findings Include: During record review for R23, it was noted that the POLST form did not contain the two dates	4 105	CORRECTIVE ACTION FOR RESIDENTS AFFECTED: R23 and representative provide with new Providers Order for Life Sustaining Treatment (POLST) which was completed and reviewed by Director of Nursing to verify compliance with completion. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN:	12/16/18

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/16/18

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4 105	Continued From page 1 that was required on the form. These two dates were: 1. Date form prepared, and 2. Date of Physician Signature. The POLST form also stated "Any section not completed implies full treatment for that section". During staff interview with RN52 on 11/16/18 at 09:39 AM, RN52 acknowledged that the POLST form was not complete and missing the required dates. RN52 then stated that the issue would be followed up and presented to the physician. A review of the facility policy on Medical Record Documentation stated "Each documentation entry or documents with multiple sections completed by multiple individuals in the medical record shall be immediately dated, timed and signed by the authorized personnel ...".	4 105	Audit of all completed Providers Orders for Life Sustaining Treatment completed to verify compliance with medical record documentation. Director of Nursing re-educated licensed nursing staff on Policies and Procedures "Medical Record Documentation" and "Advance Directives/POLST". Licensed Nursing staff provided with POLST education presentation. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: Director of Nursing, Charge Nurse and/or designee will review Providers Order for Life Sustaining Treatment (POLST) upon completion to ensure compliance with medical record documentation. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Director of Nursing will provide a report for all new/revised/discontinued Provider Order for Life Sustaining Treatment (POLST) to Nursing Home Administrator in monthly QAPI meeting to monitor on-going compliance.	
4 118	11-94.1-27(7) 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	4 118		12/16/18

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4 118	Continued From page 2 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: (7) The right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive; □ This Statute is not met as evidenced by: Based on record review and interview the facility failed to provide the resident with the provisions to formulate an advance directives for two residents (R)7 and R20 of 16 residents reviewed. This includes a written description of the facility's policies to implement advance directives and applicable State law. The residents record lacked documentation stating there was follow up to formulate the advanced directive. Findings include: 1. During the initial record review of R 7' s' electronic medical record (EMR) on 11/14/18 at 01:04 PM no advanced healthcare directives were found. 2. During the initial record review of R20's EMR, no advanced healthcare directives were found. During an interview with the Director of Nursing (DON) on 11/15/18 at 03:30 PM requested a copy of the advanced healthcare directives for both R7 and R20 and was provided only a copy of R20's physician's order for life sustaining treatment (POLST).	4 118	CORRECTIVE ACTION FOR RESIDENTS AFFECTED: Resident R7 and R20 informed and provided with written information on Advance Health Care Directive by Charge Nurse. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN: An audit completed for all residents to identify residents without an Advance Health Care Directive in place. Identified residents without an Advance Health Care Directive in place will be provided with written information on Advance Health Care Directive. For residents who are incapacitated written information on Advance Health Care Directive will be provided to the resident's representative in accordance with State Law. Policy and Procedure revised "Copy of	

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4 118	Continued From page 3 The policy on advanced directives/ POLST last revised 08/2018 was reviewed and stated...The POLST form is used by East Hawaii... Newly admitted residents may provide the facility with a previously completed copy of an Advanced Health Care Directives form (AD). The AD will be utilized for Legal Authorized Representative designation. H. If resident does not have an Advanced Health Care Directives and/ or POLST completed, staff will offer assistance in completing a POLST... During an interview with the Administrator on 11/16/18 at 9:47 who stated that the advanced healthcare directives used to be in place until a few years ago when we did away with them and started to formulate and require the POLST. While the POLST is a physician's order for life sustaining treatment it is not based on a residents rights and preferences.	4 118	Advance Health Care Directives (Living Wills and Durable Power of Attorney)to ensure residents/representatives are provided with written information on Advance Health Care Directive upon admission and Quarterly and as needed for those residents/representatives who decline to complete an Advanced Health Care Directive upon admission. Director of Nursing provided in-service presenting "Resident Rights" presentation. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: Advance Health Care Directive assessment has been developed which is automatically populated in the resident's electronic medical record upon admission for Charge Nurse and/or designee to complete. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Director of Nursing and/or designee will audit each admission to verify that resident/representative were provided with written information on Advance Health Care Directive upon admission. Social Worker and/or designee will review Advance Health Care Directives with resident/representative quarterly and as needed.	

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4 135	Continued From page 4	4 135		
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: Based on interview, record and policy review, the facility failed to protect resident's right to be free from any type of abuse that results in, or had the likelihood to result in physical harm, verbal abuse, or mental anguish in four Resident's (R) 10, R20, R22, and R30 in the sample of 16. The facility failed to provide care planning interventions and supervision to prevent three incidents involving R30. An incident on 08/09/2018 resulted in R22 striking R30 after verbal confrontation with R30. On 11/04/2018, R30 and R20 had an abusive verbal confrontation that required staff to render a show of force to prevent a physical confrontation. On 11/12/2018, R10 was involved in a verbal confrontation with R30, when he felt R30 was loud and rude to staff. This deficient practice had the potential to endanger the resident's safety and health and affect the other 24 residents residing in the extended care facilitly. Findings Include: During initial screening of residents on 11/13/2018, R25 expressed she would like to discuss concerns about R30. During a brief interview on 11/14/2018 at 10:50 AM, R25 stated, "R30 upset the "blind man (R22) to the point he went after him." He is verbally obnoxious. I give the staff credit as they are kind to him."	4 135	CORRECTIVE ACTION FOR RESIDENTS AFFECTED: In response to incident with physical altercation on 08/09/18 involving R30 and R22; R30 and R22 were immediately separated. R30 assessed for injuries with no noted injuries. R30 relocated to new room location. Notifications to Office of Health Care Assurance (08/10/18), County of Hawaii Police Department (08/09/18) and Adult Protective Services (08/10/18) completed. R30 and R22 placed on alert charting for 72 hours with no overt mood or behaviors noted. Psychiatric consultation completed for R30 on 08/10/18 for evaluation and recommendations. R30 and R22 with no further incidents to date. In response to incident verbal altercation on 11/04/18 involving R30 and R20; R30 and R20 were immediately separated. Notifications to Office of Health Care Assurance completed regarding incident. Nursing Home Administrator met with both residents on 11/07/18 to follow up with safety and provide intervention. R30 and R20 placed on alert charting for 72 hours with no overt mood or behaviors noted.	12/16/18

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4 135	Continued From page 5 During an interview with resident council members (R10, R22, R25, and R29) on 11/14/2018 at 10:45 AM R22 stated. "There's a guy (R30) here who I got into it with. He talks all the time and goes on and on. A couple of months ago I was in the same room and got sick of it and punched him." R10 stated, "He is bad to the staff how he talks to them and obnoxious. R29 stated, "He was kicked out of bingo and has to know everything about everyone's business." R10 said, "He has no respect for women." R25 stated, "He (R30) asks one of the CNA's if she'll marry him. She told him she was married, and he tells her to divorce and marry me." When asked if the resident's present felt safe, they replied "yes." R10 stated, "He's not safe in our environment." When asked to explain, R22 said, "Concerned someone will get upset with him because he's so obnoxious, always swearing and in everyone's business." Shared that R30 had been observed to be sitting alone in the dining room this morning. R10 responded. "Staff have asked him to stay away, but he gets up and goes to the tables anyway and starts talking." During an interview with Director of Nursing and Assistant Hospital Administrator (AHA) on 11/15/2018, about R30's behavior, AHA described him as "Portuguese and very talkative. He is not offensive to everyone." Asked what interventions have been put in place to prevent further altercations involving R30, and AHA stated, "We are working with them one to one to help them understand R30's communication style and separate them in the dining area. The residents committed to notify the staff if they feel frustrated with R30's conversation prior to addressing it directly with him." "There has not been a second incident with these resident's (R10, R20 and R22). The concern regarding R30's safety	4 135	R30 placed on close watch every 15 minutes. In response to incident verbal altercation on 11/12/18 involving R30 and R10; R30 and R10 were redirected by staff as they were seated at separate tables in the resident dayroom. Notifications to Office of Health Care Assurance completed regarding incident. Nursing Home Administrator met with both residents on 11/13/18 for follow up with safety and provide interventions. R30 and R10 were both placed on alert charting for 72 hours with no overt mood or behaviors noted. R30 remained on close watch every 15 minutes. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All staff completed Dementia Care Series: Abuse Prevention conducted by Director of Nursing 12/10/18. Casper Report (previous 4 quarters) was reviewed by RAI Coordinator to verify resident□s triggered for Behaviors on 11/19/18. All Behavioral Care Plans were reviewed by Director of Nursing, RAI Coordinator, Activities Coordinator and Nursing Home Administrator to ensure target behaviors are addressed with appropriate interventions. Baseline Care plans reviewed by the Charge Nurse, Social Services and/or RAI	

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4 135	Continued From page 6 discussed at Resident's Council interview was discussed. AHA stated, "No one will be able to remain here if threats are made." Clarification made, and it was reiterated that the statements made were not made as a threat but interpreted as genuine concern that due to the ongoing verbal persistence of R30, any resident might unexpectedly react and harm R30. The level of frustration verbalized at Resident's Council interview revealed the interventions to date were not adequate and concern expressed for further occurrences. During a brief interview with AHA on 11/16/2018 , additional records were requested for care plans after the three incidents. AHA was asked if there was anything that could have alerted them or factors that could have been foreseen to prevent the incident on 08/09/2018 when R30 was struck. AHA replied, "No, there was nothing." EMR reviewed R30 was known and identified on the baseline care plan as having difficult behavior, demanding and verbally abusive communication. On 08/09/2018 the RN55 was made aware by R22 that he was upset with R30 and needed to talk. R30 and R22 were left in the room unsupervised resulting in a physical altercation. Interventions put in place after the incident were not effective in reducing behaviors resulting in a second and third incident involving R30. A behavioral contract was not developed with R30 until after the third incident. On 08/09/2018 at 05:20 PM, an altercation occurred between R30 and R22. The incident report completed by Registered Nurse (RN) 55 documentation includes the following: "R22 stating earlier that he wanted to talk to R30 about squealing to MSW (Master of Social Work). R22	4 135	Coordinator to ensure care plans are in place for any noted behaviors on 11/19/18. Resident Council Meeting template revised to include Resident Safety Concerns utilized by Resident Council on 12/11/18. Nursing Home Administrator and/or Designee to provide weekly visits to residents triggering for Behaviors. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: Dementia Care Series: Actions & Reactions, Being with a Person with Dementia: Making a Difference CMS Hand in Hand education will be completed by all staff annually. Annual completion of Dementia Series education will be tracked and recorded by Director of Nursing. Casper Report will be reviewed and monitored monthly by RAI Coordinator to ensure care plans in place for triggered care areas. Baseline Care Plans will be discussed in Stand Up meeting which includes but not limited to attendees; Director of Nursing, Nursing Home Administrator, Activities Coordinator, Registered Dietician, Social Services and RAI Coordinator to ensure and verify completion of care plans/interventions to address triggered care areas. Behavioral Report developed to provide	

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4 135	Continued From page 7 states MSW talked to him and R10 during the day about complaints of them being mean to R30. Upset R30 went "behind his back" to talk to MSW instead of saying it to "his face", stated he wanted this writer to be there as witness because R30 was lying to MSW. Notified R22 that he can talk to resident but not argue or do anything physical, to call this writer when he was ready to talk. R30 was sleeping when this writer left room at 1700." "Notified by Certified Nursing Assistant (CNA)16 at 17:20 that ...R22 who was hitting ... R30 during dinner." "R22.. said he brought up the issue of R30 "squealing on him" then R30 said used profanity. R22 states he "lost it" got up and started swinging his arms trying to hit R30 who was in bed. R22 is blind and states he just went toward R30's voice. RN55 told R22 he, "should have called this writer like he promised." CNA16 states R22 was hitting the left side of R30's body, she pulled R22 away." R30 was moved to another room after the incident. Review of R30's Social Services notes by Social Worker (SW)1 include: On 08/10/2018 at 07:30 AM. R30 again stated he had no physical pain but said he was "emotionally hurt." The SW responded the staff would keep him safe. On 08/10/2018 at 02:35 PM. "At approximately 12:30 PM the resident said he did not feel safe, and felt restless and "not normal." further describing the event as a trauma. The SW said to the degree he could, R30 should try to maintain a normal routine and be involved in activities within the group. R30 said, "What if he comes in my room after me?" The SW reassured R30 that R22 was not prone to this and, with the two men being in separate spaces, it was not at all likely to	4 135	comprehensive follow up for residents who trigger for behaviors, residents with new behaviors and residents with history of behaviors. Revised Resident Council Meeting template will be utilized by Activities Department and report will be provided in Stand Up meeting which includes but not limited to attendees; Director of Nursing, Nursing Home Administrator, Activities Coordinator, Registered Dietician, Social Services and RAI Coordinator to ensure follow up with any concerns. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Completion of Dementia Care Series; Actions & Reactions, Being with a Person with Dementia: Making a Difference CMS Hand in Hand education will be tracked and recorded by Director of Nursing and report will be submitted to QAPI meeting and monitored by Nursing Home Administrator to ensure on-going compliance. Activities Coordinator will be provide a copy of the Resident Council Minutes to QAPI meeting and monitored by Nursing Home Administrator to ensure on-going compliance. Social Services will provide a Behavioral Report that will include a comprehensive follow up for residents who trigger for behaviors, residents with new behaviors and residents with history of behaviors to QAPI meeting and monitored by Nursing	

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4 135	Continued From page 8 happen." On 08/10/2018 at 02:53 PM. R30 stated he felt safe but expressed anger at his former roommate who had hit him. On 08/13/2018 at 02:00 PM. R30 spoke several times with the SW throughout the day. He complained that his former roommates were being mean to him. He described looks and them whispering. The SW said he would attempt to address it with the other men but said the [sic] he needed to give that situation time since there had been overt conflict that previous week." Review of SW1 follow up notes for R22 include: On 08/10/2018 at 07:45 AM. R22 said he was upset the SW had spoken to him about R30's concerns with him (R22). Other residents reported that R22 shouted for R30 to "shut up" loudly in the dayroom on 8/8/18." R22 said "I no care you kick me out of here." The resident (R22) said, "I tell him you come to me if you got a problem with me." He said, "Don't hide behind other people Brah." The SW also pointed out that three roommates had come and gone with R22 and the third roommate R10. The SW said that such physical attacks could not happen, as all residents needed to feel safe." On 08/24/2018 Subjective findings in R30's progress notes by Advanced Practice Registered Nurse (APRN) reviewed: "We discussed the interpersonal challenges he has been having with peers and staff. He has been in 7 care homes." APRN's assessment included "Borderline personality disorder-continues to have interpersonal problems, however willing to practice communication strategies with staff and	4 135	Home Administrator to ensure on-going compliance.	

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4 135	Continued From page 9 distancing strategies with unfriendly peers." On 11/04/2018 an Office of Healthcare Assurance (OCHA) report revealed a second incident involving R30. The event was described as follows: "R20 was heard swearing at R30. Staff heard R20 state in a very loud voice, "what! What!"; As R20 was swearing, he was approaching R30. (Both men utilize front wheeled walkers for mobility assistance.) R30 was seated with other residents; facing the front of the ...building, R30 was reacting to R20 and also began to curse at him. Staff approached both men and asked them to stop their behaviors. R20 appeared to be preparing to strike out at R30, as he was bringing his right hand backwards. However, staff was able to place themselves in a position to gain R20's attention and state, "Stop. You need to go back to your room and calm down." R30 continued his taunt. R20 began to become more upset. He was becoming more difficult to redirect. Along with the staff aide, the activity aide, as well as the housekeeper was able to render a show of force, which successfully dc-escalated [sic] the situation. R20 returned to his room. R30 was advised not to approach or antagonize R20." The report documents, "There were no issues prior to this event; as these residents had not associated with each other prior to this encounter." Causal factors identified by the facility were documented as: "R30, had settled in to the facility; he continues to have a tendency to repeat self; making persistent verbal requests of others. R20, does have instances of verbal outburst that lends to his self-isolation. There were noted precipitating factors that could explain the incident." On 11/06/2018 an email From CNA26 was sent to the Director of Nursing (DON) which said" R20 was only inches away from R30's back and ready to swing his hand on his	4 135		

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4 135	Continued From page 10 back. R20 were about to turn around when R30 started to talk and teased him to fight. R20 got more upset and unable to redirect.' "R20 had no plan to stop attacking R30." On 11/12/2018 a verbal altercation occurred between R30 and R10. The OCHA initial report describes: "R10 was trying to stop R30 from speaking loudly and rudely to the Recreational Aide." Survey team was on site 11/13/2018. RN56 nurses notes dated O7/24/2018 stated "Resident's daily routine "People say I talk too much" and identified potential barriers to his "discharge/ goals" as: "Hx difficult behavior," and "demanding + verbally abusive." comprehensive care plan dated 07/25/18 reviewed, no evidence of interventions to address identified difficult behavior and demanding, verbally abusive behavior noted. On 08/10/2018 at 10:34 AM, R30's comprehensive care plan revised after the incident on 08/09/2018, to include the following interventions: Please remind me if my verbal persistence is upsetting others." "Let me know what good behaviors look like." "Approach me in a gentle sensitive manner. Talk calmly." On 08/14/2018 Additional interventions include: "Please ask me if I am upset. Offer me reassurances, but also encourage me to distract myself in places I feel safe, such as my new room or in common areas with staff." "Allow me to vent over my feelings of frustration or anxiety, but direct me if I repeat themes after reassuring me this will not re-occur."	4 135		

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	125002		11/16/2018

NAME OF PROVIDER OR SUPPLIER

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HILO, HI 96720

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4 135	Continued From page 11 "My feelings get hurt if no one talks to me." On 09/17/2018 "Please encourage me to resume my daily routine (out for activities, engaging others in conversation, out for meals etc." "Remind me that others may not respond the way I expect them to. On 11/04/2018 After second incident, care plan revised to include: "Changed to every 15 minute monitoring due to altercation." On 11/12/2018 after the third incident, care plan revised, "I will be monitored so that another resident(s) I had a verbal altercation with will not be in the dayroom at thie[sic]same time as I am until further notice." On 11/16/2018 care plan revision, "I will have 1:1 visit with my SW/LTC Administrator to verbalize my feelings and any concerns that I have. On 11/17/2018 care plan revision "I am receiving 1:1 supervision due to verbal altercation I had with another resident (R10). 11 dc' d (discontinued) 11/20/2018. On 11/19/2018 NHA (Nursing Home Administrator) informed of behavioral contract developed and R30's agreement and signature provided.	4 135		
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:	4 148		12/16/18

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4 148	Continued From page 12 Based on observation, staff interview, and policy review, the facility failed to properly date a Peripherally Inserted Central Catheter (PICC) line sterile transparent dressing (dressing) for R135. As a result of this deficient practice, the facility put R135 at risk for infection and/or other PICC line complications. Findings Include: During an observation of a PICC line for R135 on 11/13/18 at 12:30 PM, it was noted that the dressing was not dated. During staff interview with RN57 on 11/13/18 at 12:31 PM, RN57 acknowledged that the PICC line dressing was not dated and should have been. RN57 then stated that the PICC line would be immediately assessed and dressing would be changed and dated. A review of facility policy on Vascular Access Devices; PICCs, Appendix G; PICC, Site Care and Dressing Change stated "Central PICC dressing change is a sterile procedure needing dressing kit. BioPatch and StatLock. A sterile transparent dressing of appropriate size shall be used and changed every 7 days and PRN along with BioPatch and StatLock".	4 148	CORRECTIVE ACTION FOR RESIDENTS AFFECTED: R135 PICC line immediately assessed and dressing change completed with date on 11/13/18. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN: Licensed Nursing staff re-educated on Policy and Procedure "Vascular Access Devices (VAD): (Intravenous, Arterial, Peripheral, Dialysis, PICCs, TNP) conducted by Director of Nursing. MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: PICC line management task added to electronic medical record work list for Licensed nurse to verify date on PICC line sterile transparent dressing date. Licensed nurse will confirm date on PICC line sterile transparent dressing each shift and document in PICC line management task in resident's electronic medical record on work list. Focus Rounds will be completed weekly to ensure compliance with PICC line sterile transparent dressing date. MONITORING CORRECTIVE ACTION FOP SUSTAINED CORRECTIONS:	

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4 148	Continued From page 13	4 148	Director of Nursing will audit/review electronic medical record work list task for PICC line management to assure on-going compliance. Focus Rounds will be submitted to Administrator for review and included QAPI monthly meeting to assure on-going compliance.	
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, record review, and interview, the facility failed to monitor temperatures to ensure the refrigerators/freezer were in good working condition, and stored food beyond safe "use by dates", in two kitchen refrigerators, one resident nourishment refrigerator, and a storage cabinet on the Long-term care unit. The deficiency compromised food safety for the residents. Findings Include:	4 159	CORRECTIVE ACTION FOR RESIDENTS AFFECTED: Identified expired foods were immediately removed from noted refrigerators (kitchen and resident nourishment) and storage cabinet located in long term care unit on 11/16/18. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED,	12/16/18

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4 159	Continued From page 14 On 11/16/2018 at 10:20 AM, during an interview with the Food Service Manager (FSM), the monthly refrigerator/freezer temperature logs were reviewed that revealed incomplete documentation of temperature monitoring. The FSM stated, "They are to check them twice a day and document on the log." There was no evidence the kitchen storeroom refrigerator, or kitchen storeroom freezer temperature was monitored 12 out of 31 days in August, 2018. The log revealed the kitchen "GC 14 Refer (Juices)" refrigerator was not monitored 13 out of 31 days in August, 2018. Temperature documented on 08/26/2018, 08/27/2018, 08/28/2018, and 08/29/2018 was 52 degrees Fahrenheit (F), outside the safe range (41 degrees F, or less) for refrigeration with no evidence of corrective action taken after the deviation was noted. On 08/15/2018, staff entered the comment, "couldn't find thermometer." On 11/16/2018 at 10:30 AM identified one container of tofu, and one container of sliced apples in a kitchen refrigerator with expired dates on the labels. The FSM confirmed the food, "Needed to be thrown out." On 11/16/2018 at 11:38 AM, inspection of the Long-term care nourishment room revealed one opened container of orange juice and a bowl of crystal light jello stored in the refrigerator with "use by dates" on the labels that had expired. In addition, there were eight unopened lemon water containers and two unopened orange juice containers stored in the cabinet that were beyond the "use by" dates.	4 159	AND WHAT CORRECTIVE ACTION WILL BE TAKEN: Food Service Manager (FSM) and/or designee re-educated kitchen staff on Policies and Procedures "HACCP Food Safety Program" and "Infection Control Guidelines for Food Service". Director of Nursing and/or designee re-educated staff on Policies and Procedures "HACCP Food Safety Program" and Infection Control Guidelines for Food Service". MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE: FSM and/or designee to conduct daily audit of kitchen refrigerator/freezer temperature logs to verify completion. Charge Nurse and/or designee will complete Nourishment Room Check Form daily to ensure compliance with dated foods in refrigerator/storage cabinet. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: FSM and/or designee will submit temperature log report to Nursing Home Administrator in QAPI meeting monthly for on-going compliance. Director of Nursing will submit Nourishment Room report to Nursing	

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4 159	Continued From page 15	4 159	Home Administrator in QAPI meeting monthly for on-going compliance.	
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to properly discard two medications that were stored in the Lehua Unit Medication Storage Cart. As a result of this deficient practice, two residents (Resident (R) 2, and R6) were at risk of being given an expired medication. Findings Include: 1. During an observation of the Lehua Unit Medication Storage Cart on 11/14/18 at 09:45 AM, an expired medication bottle of MAPAP was revealed in the storage drawer. This medication belonged to R6, and the label read MAPAP 160 mg/5 ml elixir, "discard after 6/18". 2. During an observation of the Lehua Unit Medication Storage Cart, on 11/14/18 at 09:46 AM, an expired medication Famotidine was revealed in the storage drawer. This medication belonged to R2, and the label read Famotidine Oral Suspension 40 mg/5 ml, "discard after 7/18/18". On 11/14/18 at 09:45 AM, RN57 acknowledged that both medications were expired and should	4 197	CORRECTIVE ACTION FOR RESIDENTS AFFECTED: Identified expired medications belonging to R6 and R2 were immediately properly discarded according to Policy and Procedure "Outdated and Unusable Drugs" on 11/14/18. IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN: Licensed Nursing staff re-educated on Policies and Procedures "Outdated and Unusable Drugs" and "Pharmerica: Medication Discontinuation & Destruction". Consultation with Pharmacist completed which resulted in implementation of medication cart auditing system. Licensed nursing staff educated on medication cart audit form. MEASURE AND SYSTEMATIC	12/16/18

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4 197	Continued From page 16 have been removed. According to facility policy on Outdated and Unusable Drugs, it stated "All outdated drugs, contaminated drugs.... shall be returned to the Pharmacy Department for proper disposal.	4 197	CHANGES TO PREVENT RECURRENCE: Licensed nursing staff will complete medication cart audit form daily. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: Director of Nursing will complete weekly audits to ensure completion of medication cart audit form and on-going compliance. Director of Nursing will provide medication cart audit report to QAPI monthly meeting.	