STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING: _____ B. WING _____	01/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

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4 000	Initial Comments A re-licensure survey was conducted on 01/08/2019 to 01/14/2019. The facility reported census was 107 residents at time of entrance.	4 000		
4 095	11-94.1-20(a) In-service education (a) There shall be a staff in-service education program that includes the following: (1) Orientation for all new employees that shall include: (A) Information to acquaint them with the philosophy, organization, program, policies and procedures, practices, and goals of the facility; and (B) Competency evaluation to ensure that staff are able to carry out their respective duties; (2) In-service training for employees who have not achieved the desired level of competence, and continuing in-service education to update and improve the skills and competencies of all employees; (3) In-service training that shall include annually, at minimum, prevention and control of infections, fire prevention and safety, disaster preparedness for all hazards, accident prevention, resident rights including prevention of resident abuse, neglect and financial exploitation, and problems and needs of the aged, ill, and disabled; (4) Competency testing for cardiopulmonary resuscitation to annually certify the nursing staff;	4 095		2/28/19

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4 095	Continued From page 1 (5) Training in oral hygiene and denture care, which shall be given to the nursing staff at least annually; and (6) Appropriate personal hygiene instructions at regular intervals shall be given to all personnel providing direct care and handling food. This Statute is not met as evidenced by: Based on record review and interviews, the facility failed to provide no less than twelve hours of in-service education for every nurse aide employed by the facility. There were seven CNAs who did not meet this requirement. This deficient practice has the potential to affect the quality of care, treatment and services provided to their residents, as various topics, such as dementia care for August 2018, was not completed by these seven CNAs. Findings Include: On 01/10/2019 at 02:51 PM, during an interview with the Director of Nursing (DON), she produced their "Mandatory In-Services Record 2018." Review of the record revealed that several of the certified nursing assistants' (CNAs) in-service education/training was not done. These staff were not new hire CNAs and the record showed they did not meet the 12 hour in-service requirements. In addition, the DON stated her administrative assistant (AA) 126 tracked and documented each certified nursing assistants' in-service education/training.	4 095	4095 1)1. Facility will identify and have employees with incomplete mandatory inservice records come in to complete all in-service requirements including but not limited to the dementia care education module. Staff identified as not completing required in-service education modules will not be scheduled to work shifts until education is appropriately completed and recorded. 2. All residents, including those with a dementia diagnosis have the potential to be affected by this deficient practice. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in education for in-service requirements. 3. Monthly education modules will be offered to all staff. All staff is required to attend and maintain their educational requirements for continued work schedules and employment. 4. Monthly audits of education records will be conducted by Administrator and/or designee and staff not meeting annual requirements will be immediately notified	

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4 095	Continued From page 2 On 01/10/2019 at 03:02 PM, during a concurrent review of the in-service record with AA126, she said some of the CNAs who did not meet the 12 hours of in-service education either worked on the weekends, were not working or were on vacation. She verified however, they were all still employed at the facility. The administrative team stated that CNA124, as an example, missed five months, completed the October inservice, and then left again on an extended trip without completing any further in-service education. It was also revealed that CNA85 came to assist in the evenings from 4:00 to 8:00 PM two to three times a week; CNA86 came to work one to two times a month; CNA81 worked two to three times a month on night shift; CNA123 worked three days a week as a part-time hire; CNA90 worked two to three times a month on night shift, and CNA87 has been out for a few months but had completed approximately 7 hours of in-service according to the record. AA126 said she tracked to see who completed their inservice, "and if they miss it, I give them the handbook to complete that inservice for that month." Per the DON, she said she and the nursing home administrator (NHA) are the ones who should be tracking it as well. The DON acknowledged they were not in compliance with this.	4 095	of their responsibility to complete necessary and outstanding inservice(s). Audits will continue to ensure 100 percent participation in education by staff. Audit data will be reported to Quarterly QA Meeting.	
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 be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon	4 118		2/28/19

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4 118	Continued From page 3 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 interview and record review (RR), the facility failed to provide documentation that residents or their representatives were given opportunities to formulate an advance directive (AD) for residents (R)5, R49, and R51 of 38 selected for review. Findings Include: 1) On 01/09/2019 at 08:59 AM, RR for R49 showed no AD, and no Physician's Order for Life Sustaining POLST. Interview with SW114 who stated she attempted to locate the AD and POLST but was unsuccessful. 2) R159 was recently admitted on 12/20/2018 for long term care placement. R159's record review found she only had a general power of attorney for financial matters and a POLST. A 01/03/2018 progress note stated an admission care conference was held 12/27/2018 with the resident and her family members present. However, there was no AD or social services entry noting the status of whether the resident had an durable power of attorney for health decisions. On 01/10/2019 at 11:43 AM, during an interview	4 118	4118 1. Social Worker met with Resident 159 to offer opportunity to complete an Advance Directive and/or POLST. Resident was given paperwork and education regarding completion of AD and/or Polst. Social Worker documented encounter with Resident 159 and will continue to offer information and assistance if resident chooses to complete AD documentation. 2. Social Worker followed up with Resident 49 and completion of Advance Directive resident received from hospital, prior to LTC admission. Resident given opportunity to complete document and meet with in-house Notary to complete Advance Directive. Social Worker documented encounter with Resident 49 and will continue to offer information and assistance if resident chooses to complete AD documentation. 3. Social Worker contacted Resident 5 Legal Guardian of record to discuss	

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4 118	Continued From page 4 with SW114, she was asked if during the admission process, whether the resident or resident's representatives were asked about an AD. SW114 stated, "It has not been discussed with her (R159)." SW114 confirmed that R159 "does not" have an AD. 3) On 01/09/2019 at 11:30 AM during a review of the R5's clinical record, it was revealed R5 had a POLST, and an order granting petition for the appointment of co-conservators and co-guardians. However, an AD was not found in her record. On 01/10/2019 at 11:41 AM, during an interview with SW114, she verified this resident did not have an AD in her chart. The facility's policy and procedure, "Resident Representation," (Rev. date: 10/25/99), stated at the section for Advance Directives (AD): "1. Upon admission and during their residency at the facility, the social worker will discuss advance directives with the residents and their families or responsible representative and encourage them to execute these documents . . . . 4. The Social worker ensures that the attending physician has a copy of the advance directives and a copy is placed in the resident's medical chart."	4 118	Advance Directive. Social Worker provided Guardian with information and paperwork regarding AD and documented encounter in resident record. Resident 5 does have a completed POLST in the record. 4. Social Worker met with and gave Resident 51 an opportunity to complete an Advance Directive. A completed Advance Directive is now in Resident 51□s record with supporting documentation from the Social Worker. Pursuant to facility policy, Advance Directives, including but not limited to Hawaii Advance Health Care Directive, Living Will, Power of Attorney, DPOAHC, or Guardianship will be asked for at time of admission to Pearl City Nursing Home. Response will be noted on Admission Agreement. If there is no Advance Directive at time of admission, Admission Associate will offer an Advance Directive form to the resident and/or responsible party and refer the resident and/or responsible party to Social Services for further information and assistance with completion of document if they so choose. Admitting nurse will also ask the resident and/or responsible party and document response on the revised Nursing Admission Checklist. The resident/family will be asked throughout their stay at PCNH (during the admission process, the nursing admission process, the social work assessment phase and every time that Interdisciplinary Team	

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4 118	Continued From page 5	4 118	meetings are held) the question of whether or not they have an Advanced Directive. If the response is yes, a copy should be in the residents medical record. If no copy is found, the resident and/or family/responsible party should be asked to bring in a copy. If the response is no, then the resident and/or family/responsible party should be asked if they wish to complete an advanced directive, at that time. The resident and/or family/responsible party s response will be documented in the medical record. Social Services will review all charts to determine if any lack Advance Directives or documentation that the opportunity to formulate one was given. If there is no documentation that the opportunity was presented, the Social Worker will follow up with the resident/family and/or responsible party to determine possible outcomes of that decision and document once a decision has been made. Changes were made to Admissions forms to reflect documentation that Advance Directives were covered and the opportunity to formulate one was presented. At admissions and all scheduled Care Conferences, the chart will be reviewed to determine if the resident, family and/or responsible party would like to consider an Advance Directive at that time if one has not already been formulated. Social Service will monitor and report Advance Directive compliance at Quarterly QA meeting.	

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4 136	Continued From page 6	4 136		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations, record reviews (RR) and interviews the facility failed to promote the prevention of pressure ulcer (PU) development; and prevent development of additional PU for one of 38 residents (R) 77 on the survey sample. As a result of this deficient practice, R77 developed a Stage 4 PU to the left (L) ear six days after admission; and, Stage 4 PU to the right (R) ear 13 days after admission. Findings Include: On 01/10/2019 at 08:05 AM observed R77 lying in bed with adhesive bandage covering top of L ear . RR on R77 included admission orders dated 12/10/2018, the resident was admitted to hospice and included "skin care treatment orders/wound	4 136	4136 1) 1. R77 comprehensive care plans reviewed. Care plans for pressure injury updated and tailored for specific skin impairments including pressure injuries, skin tears and bruises. Nursing staff and Agency educated to care plan and intervention updating regarding pressure injuries. Wound Consultant immediately implemented a weekly education series for all licensed nurses and clinical staff for complete skin assessment protocol, communication, documentation and wound care modalities. 2. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members to identify and review active and at-risk residents, including new admissions and long-term care, for skin	2/28/19

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4 136	Continued From page 7 care / skin tear: change dressing to PEG site daily." Review of R77's physicians orders (PO) included a telephone PO dated 12/17/2018, " Cleanse L ear helix with normal saline (NS), pat dry, apply Medihoney to open areas, and cover with absorbent dressing daily (QD) and as needed (PRN) until healed (Diagnosis: Stage 4 PI)"; signed by the physician. Additionally, a "Wound Assessment Details Report," with date of 12/29/2018 noted a facility acquired pressure ulcer on the R ear at Stage 4. Description of the R ear wound included: "tissue bright pink to red 50%; slough loosely adherent 40%; necrotic soft, adherent 10%; light serosanguineous exudates; maceration; and, measured 1.80 x 1.50 x unknown (LxWxD); area 2.70 cm2; no tunneling." On 01/10/2019 at 08:44 AM interviewed RN4 and inquired how R77's PU's on both ears started, and RN4 stated that R77 had L side weakness and tends to lie on L side. Reviewed R77's medical records with RN4 and on the 12/16/2018 skin lesion assessment, "Stage 2 (0.2 x 0.8 cm); serosanguineous scant drainage; open edge pink/red; L ear tip (Helix) superior; and on 12/19/2018 Stage 4; 0.8 cm x 0.5 cm," written by RN29 (facility wound nurse). According to RN4, the unit manager (UM)121, corrected the wound from Stage 2 to Stage 4. On 01/10/2019 at 11:25 AM observed RN29 do dressing change for PU on R77's bilateral ears. According to RN29 both ears were at Stage 4 due to ears have no muscle tissue or subcutaneous tissue just cartilage. The RN29 cleansed PUs with NS, applied medihoney and absorbent bandage to both ears. The R77 was observed lying on back and had rolled towel at L side of head to position off of ear. Inquired of RN29 if PU to ears happened due to R77 not turning q	4 136	impairments/pressure injuries relative to diagnoses, medications, surgical procedures, etc. 3. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members to collaborate with wound consultant and participate in wound rounds, along with charge nurses, treatment nurses, and CNAs on a weekly basis, in addition to quality of care weekly monitoring. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in educating staff regarding skin impairment reporting, daily skin impairment monitoring in treatment administration record, updating of wound care plan interventions, etc. Modification of weekly quality of care forms and monitoring procedures completed. Skin impairment in-services by wound consultant implemented and will remain ongoing to enhance clinical staff competencies. Skin impairment topics will beincluded in LN and CNA monthly meetings. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will perform weekly skin rounds with Wound Consultant. Any discrepancies will be resolved immediately. Any problematic trends will be reported at the quarterly QA meetings for discussion.	

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(every) 2 hours (hrs), and RN29 stated that R77 is turned q 2 hrs but tends to turn head to the left.

The care plan problem list dated 12/11/2018 included a care plan (CP)9 "At Risk for Skin Breakdown," that included interventions for staff to: assess skin daily during activity of daily living (ADL) care and report changes to charge nurse; reinforce importance of mobility, turning or ambulating; turn and reposition q 1-2 hrs and PRN; maintain proper body alignment; and, provide pressure relief interventions as needed based on skin assessments.

On 12/17/2018 a comprehensive CP was developed for, "Pressure Ulcer; Site: L ear helix." The CP goal was for resident to receive stage appropriate wound care, experience pressure reduction, and controlled risk factors for prevention of additional ulcers within the next 14 days. On 12/29/2018 a comprehensive CP13 was developed for pressure ulcer on the R ear midsection; "Pressure ulcer noted on the R ear mid section (St. IV)."

On 01/11/2019 at 10:18 AM observed wound care assessment done by contracted wound specialist (WS) and RN26. The WS assessed, measured, applied treatment of medihoney and dressed both ears with bandages. The WS commented that the PU on the R ear was improving but the PU on the L ear was taking longer because R77's head leaned towards the L. The WS stated that R77 lying on ears caused PUs and when staff off-loaded the head from the L side, PU on the R ear started.

On 01/11/2019 at 01:21 PM interviewed RN4 and inquired if R77's PU to ears were avoidable or unavoidable and RN4 stated that PU's were

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avoidable because staff should turn resident q two hours. Inquired whether PU started because staff did not reposition R77 off of ears, and RN4 stated R77 tends to turn towards the L side (weak side) even if staff reposition. Staff were supposed to position R77's head by using pillow to off-load on ears.

On 01/14/2019 at 07:23 AM observed R77 lying on back and L ear open to air with gauze dressing underneath with scant serosanguineous drainage and towel roll to R of pillow. Inquired of RN4 if R77's PU on L ear now left open to air. RN4 stated that should be covered with foam dressing, then went to R77's bedside to close dressing shut as adhesive bandage didn't close properly.

On 01/14/2019 at 11:11 AM interviewed UM121 and inquired about R77's PU to both ears. The UM121 stated that PU's probably from nasal cannula (NC) tubing because at admission R77 was flaccid and couldn't move. Staff positioned R77 to off-load on L ear and that's when PU on R ear started. The UM121 stated that facility staff didn't want to switch R77 to oxygen mask because there would be more pressure points from a mask. The UM121 further stated that R77 was referred to the wound consultant, provided PO for PU treatment, and PU CP implemented, with a separate PU CP for the R ear when it occurred.

Inquired of UM121 what was done differently after PU on R ear was noted, and he stated that WS educated staff and the treatment nurse should have updated the CP after received education. Queried UM121 on his role in regards to pressure ulcer development and response was that he monitored whether wound consultant followed treatment plan, and discussed in weekly wound

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4 136	Continued From page 10 meetings. On 01/14/2019 at 12:14 PM interviewed agency RN131, who stated that it was her 3rd time to work at the facility as treatment nurse. RN131 finished treatment dressing to R77's L thigh wound and PU on both ears. RN131 described the PU to the R ear as drying, and PU on L ear still open The RN131 stated that R77's treatment plan was followed and found in the unit's treatment book. The RN131 further stated that R77 was weaned from oxygen yesterday and no longer using NC. The facility did not promote the prevention of pressure ulcer development and prevent development of additional pressure ulcers for R77. Based on observations, record reviews (RR) and interviews the facility failed to promote the prevention of pressure ulcer (PU) development; and prevent development of additional PU for one of 38 residents (R) 77 on the survey sample. As a result of this deficient practice, R77 developed a Stage 4 PU to the left (L) ear six days after admission; and, Stage 4 PU to the right (R) ear 13 days after admission. Findings Include: On 01/10/2019 at 08:05 AM observed R77 lying in bed with adhesive bandage covering top of L ear . RR on R77 included admission orders dated	4 136		

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4 136	Continued From page 11 12/10/2018, the resident was admitted to hospice and included "skin care treatment orders/wound care / skin tear: change dressing to PEG site daily." Review of R77's physicians orders (PO) included a telephone PO dated 12/17/2018, " Cleanse L ear helix with normal saline (NS), pat dry, apply Medihoney to open areas, and cover with absorbent dressing daily (QD) and as needed (PRN) until healed (Diagnosis: Stage 4 PI)"; signed by the physician. Additionally, a "Wound Assessment Details Report," with date of 12/29/2018 noted a facility acquired pressure ulcer on the R ear at Stage 4. Description of the R ear wound included: "tissue bright pink to red 50%; slough loosely adherent 40%; necrotic soft, adherent 10%; light serosanguineous exudates; maceration; and, measured 1.80 x 1.50 x unknown (LxWxD); area 2.70 cm2; no tunneling." On 01/10/2019 at 08:44 AM interviewed RN4 and inquired how R77's PU's on both ears started, and RN4 stated that R77 had L side weakness and tends to lie on L side. Reviewed R77's medical records with RN4 and on the 12/16/2018 skin lesion assessment, "Stage 2 (0.2 x 0.8 cm); serosanguineous scant drainage; open edge pink/red; L ear tip (Helix) superior; and on 12/19/2018 Stage 4; 0.8 cm x 0.5 cm," written by RN29 (facility wound nurse). According to RN4, the unit manager (UM)121, corrected the wound from Stage 2 to Stage 4. On 01/10/2019 at 11:25 AM observed RN29 do dressing change for PU on R77's bilateral ears. According to RN29 both ears were at Stage 4 due to ears have no muscle tissue or subcutaneous tissue just cartilage. The RN29 cleansed PUs with NS, applied medihoney and absorbent bandage to both ears. The R77 was observed lying on back and had rolled towel at L side of	4 136		

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4 136	Continued From page 12	4 136		

head to position off of ear. Inquired of RN29 if PU to ears happened due to R77 not turning q (every) 2 hours (hrs), and RN29 stated that R77 is turned q 2 hrs but tends to turn head to the left.

The care plan problem list dated 12/11/2018 included a care plan (CP)9 "At Risk for Skin Breakdown," that included interventions for staff to: assess skin daily during activity of daily living (ADL) care and report changes to charge nurse; reinforce importance of mobility, turning or ambulating; turn and reposition q 1-2 hrs and PRN; maintain proper body alignment; and, provide pressure relief interventions as needed based on skin assessments.

On 12/17/2018 a comprehensive CP was developed for, "Pressure Ulcer; Site: L ear helix." The CP goal was for resident to receive stage appropriate wound care, experience pressure reduction, and controlled risk factors for prevention of additional ulcers within the next 14 days. On 12/29/2018 a comprehensive CP13 was developed for pressure ulcer on the R ear midsection; "Pressure ulcer noted on the R ear mid section (St. IV)."

On 01/11/2019 at 10:18 AM observed wound care assessment done by contracted wound specialist (WS) and RN26. The WS assessed, measured, applied treatment of medihoney and dressed both ears with bandages. The WS commented that the PU on the R ear was improving but the PU on the L ear was taking longer because R77's head leaned towards the L. The WS stated that R77 lying on ears caused PUs and when staff off-loaded the head from the L side, PU on the R ear started.

On 01/11/2019 at 01:21 PM interviewed RN4 and

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inquired if R77's PU to ears were avoidable or unavoidable and RN4 stated that PU's were avoidable because staff should turn resident q two hours. Inquired whether PU started because staff did not reposition R77 off of ears, and RN4 stated R77 tends to turn towards the L side (weak side) even if staff reposition. Staff were supposed to position R77's head by using pillow to off-load on ears.

On 01/14/2019 at 07:23 AM observed R77 lying on back and L ear open to air with gauze dressing underneath with scant serosanguineous drainage and towel roll to R of pillow. Inquired of RN4 if R77's PU on L ear now left open to air. RN4 stated that should be covered with foam dressing, then went to R77's bedside to close dressing shut as adhesive bandage didn't close properly.

On 01/14/2019 at 11:11 AM interviewed UM121 and inquired about R77's PU to both ears. The UM121 stated that PU's probably from nasal cannula (NC) tubing because at admission R77 was flaccid and couldn't move. Staff positioned R77 to off-load on L ear and that's when PU on R ear started. The UM121 stated that facility staff didn't want to switch R77 to oxygen mask because there would be more pressure points from a mask. The UM121 further stated that R77 was referred to the wound consultant, provided PO for PU treatment, and PU CP implemented, with a separate PU CP for the R ear when it occurred.

Inquired of UM121 what was done differently after PU on R ear was noted, and he stated that WS educated staff and the treatment nurse should have updated the CP after received education. Queried UM121 on his role in regards to pressure ulcer development and response was that he

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4 136	Continued From page 14 monitored whether wound consultant followed treatment plan, and discussed in weekly wound meetings. On 01/14/2019 at 12:14 PM interviewed agency RN131, who stated that it was her 3rd time to work at the facility as treatment nurse. RN131 finished treatment dressing to R77's L thigh wound and PU on both ears. RN131 described the PU to the R ear as drying, and PU on L ear still open The RN131 stated that R77's treatment plan was followed and found in the unit's treatment book. The RN131 further stated that R77 was weaned from oxygen yesterday and no longer using NC. The facility did not promote the prevention of pressure ulcer development and prevent development of additional pressure ulcers for R77.	4 136		
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 observations, record reviews, interviews and review of the facility's policies and procedures, the facility failed to ensure there was sufficient qualified nursing staff available at all times to provide nursing and related services to	4 148	4148 1) 1. R77 comprehensive care plans reviewed. Care plans for pressure injury updated and tailored for specific skin impairments including pressure injuries, skin tears and bruises. Nursing staff and	2/28/19

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4 148	Continued From page 15 meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. Cumulative findings included the development of facility acquired pressure ulcers for physical harm; resident reports of psychosocial distress due to delayed personal hygiene to change briefs; family report of need to come to facility during meal times because lack of staff to feed residents incapable of self-feeding; nurse comments of having to work double shifts; and the lack of development of resident-centered care plans. Findings Include: 1) On 01/11/2019 at 12:21 PM reviewed R77's pressure ulcer (PU) care plans (CP) with RN4 as he stated that PUs were avoidable because staff should turn resident q (every) two hours (hrs). RN4 stated that staff turned R77 q two hrs but resident tends to turn towards the left (L) side, and a pillow was used to position R77's head to off-load on ears. The RN4 couldn't find in R77's CP interventions that a pillow should be used to position R77's head to off-load on ears. On 01/11/2019 at 12:45 PM observed R77 with towel roll under the R shoulder area and inquired of CNA how towel roll, placed in shoulder area, kept R77's head from moving. The CNA did not have an answer and stated that when R77 was admitted she/he was unable to move head side to side but now able to and can now track with eyes. On 01/14/2019 at 11:11 AM interviewed UM121 and he stated that R77's PU on the ears were probably from the nasal cannula (NC) tubing for oxygen. UM121 further stated that at admission R77 was flaccid and couldn't move and head	4 148	Agency educated to care plan and intervention updating regarding pressure injuries. Wound Consultant immediately implemented a weekly education series for all licensed nurses and clinical staff for complete skin assessment protocol, communication, documentation and wound care modalities. 2. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members to identify and review active and at-risk residents, including new admissions and long-term care, for skin impairments/pressure injuries relative to diagnoses, medications, surgical procedures, etc. 3. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members to collaborate with wound consultant and participate in wound rounds, along with charge nurses, treatment nurses, and CNAs on a weekly basis, in addition to quality of care weekly monitoring. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in educating staff regarding skin impairment reporting, daily skin impairment monitoring in treatment administration record, updating of wound care plan interventions, etc. Modification of weekly quality of care forms and monitoring procedures completed. Skin impairment in-services by wound consultant implemented and will remain ongoing to enhance clinical staff competencies. Skin impairment topics will beincluded in LN and CNA monthly meetings. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary	

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4 148	Continued From page 16 rested on a soft pillow, with the only hard surface being the NC tubing around the ears. Queried whether a CP was developed to prevent PU's from developing with NC use, and UM121 stated that a PU CP9 was implemented, and subsequently a separate PU CP13 was developed for the R ear. Inquired what was done differently from CP9 to CP13, and UM121 stated that the wound specialist educated staff and CP should have been updated by treatment nurse after education. On both CP9 and 13 there were no interventions to prevent PU on ear from NC. The facility failed to continually assess and develop comprehensive PU CPs for R77 and the resident acquired PUs to both ears after admission to the facility. Also, R77 had developed a skin wound on the L inner thigh close to where Foley tubing was secured, that was not yet diagnosed by the physician at time of survey. 2) Review of R159's, R111's and R109's baseline care plan status revealed licensed staff failed to develop and implement baseline care plans (comprehensive care plans were developed in lieu of them), yet not within 48 hours of admission, and failed to ensure written summaries were provided to the residents and/or their representatives (refer to F655). 3) Review of R33's and R35's comprehensive care plans revealed a failure to ensure each resident's highest practicable physical, mental, and psychosocial well-being was provided as resident-centered care plans were not developed for the R33's limited range of motion (ROM) and R35's bruise and limited ROM (refer to F656). A family (F) member 1 for R35 said the facility's	4 148	team members will perform weekly skin rounds with Wound Consultant. Any discrepancies will be resolved immediately. Any problematic trends will be reported at the quarterly QA meetings for discussion. 2) 1. R159 comprehensive care plans reviewed and summary given to active resident. Care plans reviewed and added for insulin, diuretics, and blood thinners. Nursing staff and Agency staff educated to comprehensive/baseline care plans. 2. Baseline care plan will be completed for all future admissions and diagnoses and medications will be reviewed for care plan development. 3. Admission checklist modified to include initiation of baseline care plan. Developed new baseline care plan form and summary format. Created orientation checklist for agency to include care plans and skills. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in educating staff and monitoring care plan development on a weekly basis for 4 weeks, bi-weekly for 4 weeks, monthly thereafter and during care conferences. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will perform admission, monthly and quarterly audits. Any discrepancies will be resolved immediately. Any problematic trends will be reported at the quarterly QA meetings for discussion. 2) 1. R111 comprehensive care plans reviewed. Care plans reviewed and added	

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4 148	Continued From page 17 staffing was "different now" with a lot of agency staff. F1 said if she did not come to feed R35, she was not assured the staff would be able to feed R35 timely because there were many residents who needed to be assisted with not enough staff. 4) During the Resident Council (RC) interview conducted on 01/09/2018 at 10:15 AM, two residents voiced concerns of the lack of staffing on their units. One resident confidentially shared on her fourth floor unit, they were often short of staff and staff did not come timely when she called for them. The resident stated it could take approximately 30 minutes for nursing staff to attend to her on the night shift, especially when she needed to be changed or cleaned. The resident said although she used her call light, one CNA often would not be able to attend to her because they were short of staff. Another resident also confidentially shared that on her third floor unit, during the day, there often was only one activity aide in the dining room. This resident said because the other CNAs "are busy feeding and giving showers, so when you want to go, you have to wait and have no way of calling somebody." She said she has witnessed an "old timer" CNA tell a resident, "You have to wait," and felt uncomfortable with how the resident was told this. This resident did not want to identify the "old timer" CNA, but stated she witnessed this upon her recent admission to the facility. 5) On 01/10/2019 at 06:30 AM, the resident on the fourth floor stated they had three CNAs for the night, and the response time "was good." The resident verified it was when there were only two CNAs for the night shift that it took as long as	4 148	for diuretic/swelling, portacath, colostomy and use of antibiotic. Summary unable to be given as resident is no longer present in the facility. Nursing staff and Agency educated to comprehensive/baseline care plans. 2. Baseline care plan will be completed for all future admissions and diagnoses and medications will be reviewed for care plan development. 3. Admission checklist modified to include initiation of baseline care plan. Developed new baseline care plan form and summary format. Created orientation checklist for agency to include care plans and skills. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in educating staff and monitoring care plan development on a weekly basis for 4 weeks, bi-weekly for 4 weeks, monthly thereafter and during care conferences. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will perform admission, monthly and quarterly audits. Any discrepancies will be resolved immediately. Any problematic trends will be reported at the quarterly QA meetings for discussion. 3) 1. R109 comprehensive care plans reviewed. Summary unable to be given as resident is no longer present in the facility. Nursing staff and Agency educated to comprehensive/baseline care plans. 2. Baseline care plan will be completed for all future admissions and diagnoses and medications will be reviewed for care plan development.	

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4 148	Continued From page 18 30 minutes for her needs to be met. The fourth floor nursing unit was identified as the more "subacute" unit with some residents who are ventilator dependent. 6) On 01/10/2019 at 06:59 AM, a confidential interview with three third floor night shift CNAs was done. They stated they are usually staffed with two CNAs at night with the exception to add an additional CNA if they have more restless residents to care for. The three CNAs said one resident likes to toilet herself and stands often and there were three other residents who were often restless at night. They said they were all in different rooms attending to them, and having an extra third CNA helped a lot. They said their fall rate was low because they took it upon themselves to literally "run" to get to a resident's bedside when they heard any slight noise, "even like the rubbish can moving." Otherwise, they acknowledged it was harder to be staffed with only two CNAs at night with residents who were often restless. 7) On 01/10/2019 at 09:14 AM, per CNA40, she said for the third floor, the CNAs help one another. CNA40 confirmed this floor had a lot of residents requiring assistance with feeding, and said, "I don't want to lie," hesitated, and continued on to say they help each other out and try their best to serve the residents. 8) A closed record review for R111 revealed a late 11/24/2018 nursing entry for a 11/23/2018 entry. The licensed nurse wrote a family member of R111 was "so upset regarding what happened, . . . made her very anxious, pressed the call light and been waiting for someone to come but no one attended her for 30 minutes per resident."	4 148	3. Admission checklist modified to include initiation of baseline care plan. Developed new baseline care plan form and summary format. Created orientation checklist for agency to include care plans and skills. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in educating staff and monitoring care plan development on a weekly basis for 4 weeks, bi-weekly for 4 weeks, monthly thereafter and during care conferences. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will perform admission, monthly and quarterly audits. Any discrepancies will be resolved immediately. Any problematic trends will be reported at the quarterly QA meetings for discussion. 3) 1. R33 comprehensive care plans reviewed. Care plans added for Splint, Range of Motion and Restorative Nursing. Nursing staff, RNAs and Agency staff educated to care plan, restorative care flow record and initiating and updating care plans. 2. Director of Nursing, Nursing Supervisors, RNAs, Rehab and relevant Interdisciplinary team members to identify residents on splints/braces with Rehab collaboration and identify residents on RNA program with RNA collaboration. 3. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members to participate in educating all staff in initiation of Splint/ROM/RNA care plans, monitoring of restorative care flow record, and proper documentation	

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4 148	Continued From page 19 9) On 01/14/2019 at 09:00 AM, an interview with the DON was done. She acknowledged they have had staffing concerns and worked with adding an additional agency to fill the shifts. The DON acknowledged the fourth floor nursing unit, "because of subacute, our staffing is done differently there," but could not elaborate on how it is done differently to ensure the residents' care needs were being met on all shifts. In addition, the DON was vague in her response to various questions, such as what her process was to ensure the residents were being assessed and care plans were being developed and implemented. The DON said she has lost "old timers, I have 100% change in my nursing leadership." The DON then referenced "a process" using a reference book for her new unit managers to use. However, she confirmed she has not done any training with her nursing staff for, "this guide, that relates specifically to long term." The DON further said for their baseline care plans, "it was a product" she pushed forward, but other administrative staff did not agree with it so they were deadlocked over it. Hence, the baseline care plans nor their care plan policy had not been updated to reflect the new regulatory requirements and the DON affirmed she did not provide the long term care guidance to her new managers/nursing staff. 10) An anonymous complaint investigation was also reviewed during the survey related to the lack of sufficient staffing. Although the resident was not identified, based on the information provided by the complainant and the survey findings, the SA substantiates the allegation of the lack of staff which affects nursing's core ability to identify, assess, develop, implement and revise necessary care plans for their residents.	4 148	and communication. Collaboration with Rehab for appropriate use and documentation for splints/braces when indicated. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will perform monthly audits during RNA/Rehab meetings. Any problematic trends will be reported at the quarterly QA meetings for discussion. 3) 1. R35 comprehensive care plans reviewed. Bruise care plan reviewed and updated. Nursing staff educated to care plan initiating, completion and update practice. Feeding assignments and protocol reviewed with Charge Nurse and assigned staff to ensure residents receive timely and appropriate assistance with ADL needs, including feeding assistance. Charge Nurse to assign staff and ensure tasks are appropriately carried out. 2. Director of Nursing, Nursing Supervisors, RNAs, Rehab and relevant Interdisciplinary team members to identify residents on splints/braces with Rehab collaboration and identify residents on RNA program with RNA collaboration. 3. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members to participate in educating all staff in initiation of Splint/ROM/RNA care plans, monitoring of restorative care flow record, and proper documentation and communication. Collaboration with Rehab for appropriate use and documentation for splints/braces when indicated. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary	

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4 148	Continued From page 20) Interview on 01/08/2019 at 9:55 AM with Resident (R)96 stated "I talked with the supervisor and told him but nobody is taking us seriously that it takes 2-3 hours to get my diaper changed." R96 goes on to say that last night, I wanted to get something to make me warm and she doubled the sheets to make me warm. Staff said "oh there are no blankets." A couple of weeks ago, there was no socks. I had to tell my wife to go buy me socks because my feet was so cold." It's the nurses who say, "I'll be back and they don't get back. I wait 2-3 hours." During the relicensing survey, complaint 5669 was investigated. An observation along with interview was conducted with R91's family (F) member (F2) on 01/09/2019 at 8:28 AM. F2 Stated that sometimes, the temperature is at 68 degrees but lately it's gotten better. F2 further states that a lot of nurses are working double time and they are tired. "I am worried that they are so tired and the patients are being neglected. Something bad could happen, like a wrong medication administered." Interview and concommitant observation with Unit manager (UM)115 who stated that the air is at 72 degrees to accomodate the comfort of the residents and showed this surveyor the temperature reading. Temperature was confirmed at 72 degrees. Interview and observation on 01/10/2019 at 6:39 AM R96 stated "I asked for a blanket last night and they gave me two sheets." I'm cold but it's too late. They said they had no blankets. This surveyor validated that the resident had double sheets. At 6:45 AM, CNAs were doing change of	4 148	team members will perform monthly audits during RNA/Rehab meetings. Any problematic trends will be reported at the quarterly QA meetings for discussion. 4) 5) 6) 7) 1. All residents have the potential to be affected by the deficiency of sufficient nursing staff. A review of the Facility Assessment tool and staffing assignments was performed to ensure resident safety and needs are being met in a timely and appropriate way and ensuring nursing competencies are meeting the requirements of all current residents. All nursing staff reminded that resident care is priority, resident call lights should be answered in a timely manner, resident treatment and services completed per order and care plan, care plans and care interventions documented appropriately and resident's personal preferences and choices supported. 2. Facility will ensure that adequate staffing is available to meet the needs of all residents. Nursing staff will be assigned to ensure resident safety and nurse's core ability to identify, assess, develop, implement and revise necessary care plans for residents. As we have been doing, facility will continue to work with Human Resources Department to advertise, fill and/or create vacant positions to ensure a competent and adequate labor pool, and retention of existing staff. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in ensuring the importance of making	

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4 148	Continued From page 21 shift and this surveyor asked CNA if they had any blankets. Observed delivery of a cart from laundry department. No blankets were noted on the cart that was delivered. Checked the supply room where the CNAs stated that they stock their portable carts with blankets. Carts are located throughout the floor. There were no blankets in the supply room. Confirmed with Clinical Nurses Aide (CNA)52 who stated that they don't have any blankets on the 4th floor. CNA 52 stated "I had to go to the 3rd floor to get a blanket." Interview on 01/10/2019 at 9:06 AM with Recreational Coordinator (RC)127 stated "On the fourth floor, there is only me." There is only one staff because this is the rehab floor and there is less attendance. It's 8 hours a day and 7 days a week. All residents can participate in activities on any floor. We have a part-time position for sub-acute level to designate the ones that have difficulty coming out of bed, like the trachs. The position has been in place shortly after we started about 3-4 years ago. This is to accomodate more bedside visits, one to one. We set their bedside tables up. However, it's been vacant or six months. I've had students and some CNAs but haven't been able to find anyone. Activity Aide (AA)128 will dedicate part of her day where she will go one to one on the floor. She spends roughly 1-1/2 hours seeing residents on the floor. Interview with AA128 at 01/10/2019 at 9:17 AM - I go on the floor almost every day, like in the morning, I greet them, talk story. I give the newspaper, let them know the lunch and dinner. I go to every room. Since I start at 8:00 AM, I spend about one hour and 15 minutes because I have to come here before 9:15 AM. 01/11/2019 at 5:33 AM - Interview with Registered	4 148	resident-centered care a priority and participate in a monthly staffing focus meeting to review schedules, open shifts, recruitment, and retention practices. Input from Direct care staff members will be included in the staffing meetings to gain insight on staffing. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will conduct random call light response audits weekly and monitor response times to assist in determining adequate staffing for resident census, on a weekly basis. Any problematic trends will be reported at the quarterly QA meetings for discussion. 8) 1. No corrective action could be accomplished for the resident found to be affected because specific resident is no longer present in the facility. During the course of Resident 111□s stay, the interdisciplinary team, hospice agency team, family members and resident met frequently to address resident□s needs and anxiety issues, and to ensure Resident□s needs were being appropriately addressed and met. 9) 1. Facility has released DON due to performance related deficiencies and concerns brought to the Administrator by staff and other nursing managers. 2. Facility is actively recruiting for a new DON. Duties will be performed by facility Nursing Managers and Administrator to ensure all training, education, staffing, policies and procedures are adhered to according to all license requirements.	

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4 148	Continued From page 22 Nurse (RN)30 who wanted to remain anonymous because of "retaliation." Queried RN30 regarding how often she has to work overtime, how much agency staff is being used, how are current staffing needs determined? RN30 stated "Staffing has been bad since the last survey. Our sister facility transferred their vents here and admin didn't increase the staffing to accommodate the level of acuity. They don't see what our needs are . It's not safe when we have two CNAs and a lot of times we are short CNAs. When we are short CNAs, it is difficult. We just had a batch of new nurses in September that are in training. A lot of times, we will train them and they stay for a year and they leave because they see how it is. I work at times 16 hours a day for a week and come in on my day off because if their short, the residents will suffer and there are too many newbies who cannot function as house manager. It seems that administration does not see how short we are, either nurses or CNAs or both. We want change. A lot of nurses want change. We are not a union. They will mandate us to stay and I have worked five days in a row of 16 hours at a time. It is getting better but I hope the new batch of nurses will stay. We have two agency nurses tonight and one RN on orientation. Our census is 33, capacity is 41. We need three CNAs. Interview on 01/11/2019 at 545 AM with RN130. I am an agency nurse and I've been here for three days. When I first started coming here, you get oriented to one side, 2nd and 3rd floor. Orientation on the 4th floor is five days and for the sub-acute, I took a respiratory class. Interview on 01/11/2019 at 5:55 AM with RN9 states "I've been training since December. I will train a total of ten shifts for 4th floor A and B side.	4 148	3. The Staff Development Coordinator, who has many years of nursing management experience, is working with the current Nursing Managers to train them on a comprehensive overview of long term care and how to properly manage their units to ensure quality of care for all the residents. 4. After the Staff Development Coordinator is comfortable with the level of training completed by the Nursing Managers, she will periodically meet with them and the Administrator to follow-up on their development. The future Director of Nursing will take over the role of mentoring the Nursing Managers once someone is hired. 10) 1.No corrective action could be accomplished for the residents found to be affected because specific residents were not identified. All residents have the potential to be affected by the deficiency of sufficient nursing staff. A review of staffing assignments will be performed to ensure resident safety and needs are being met in a timely and appropriate way and allowing for nursing core abilities to identify, assess, develop, implement and revise necessary care plans for residents needs. All nursing staff reminded that resident care is priority, resident call lights should be answered in a timely manner, resident treatment and services completed per order and care plan, care plans and care interventions documented appropriately and resident's preferences and choices supported. 2. Facility will ensure that adequate	

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4 148	Continued From page 23 Two days on my own and three days for sub-acute. I also had a respiratory class. Interview on 01/11/2019 at 6:06 AM with RN129 states I haven't been here since November but it was unsafe then. We were short for CNAs. As a nurse, when it is short, it pulls me away from the duties of the RN because we can't ignore lights. It was short staffed when I came in November. Tonight it's not too bad. Interview on 01/11/2019 at 6:21 AM with CNA99 states "sometimes they mandate us to stay for day shift, either four hours or eight hours to help with vital signs, get residents up. Usually, we should have 3 CNAs but a lot of times we have two and evening stays back to help with vitals. A lot of CNAs work 16 hours. It happens a lot. Interview on 01/11/2019 at 6:30 AM with RN30 stated "we usually have a treatment nurse but today we only have four with one orientee. The treatment nurse helps although they don't consider it a permanent position". Today we are short for treatment nurse and all week. We are short for a CNA today. Evening shift functions on four and pretty much short all week. On Monday, two evening shifts stayed back to for nights because we only had one CNA, so CNA was mandated to stay over. Interview on 01/11/2019 at 8:33 AM with Nursing Supervisor (NS)131 stated "the treatment nurse is not an actual position. CNA level 2 can fill that position but it has to be a CNA2. If we have extra nurses, we try to fill it. Interview on 01/11/2019 at 9:02 AM with Director of Nursing (DON) stated "the staffing is done differently on 4th floor because of the subcute	4 148	staffing is available to meet the needs of all residents. Nursing staff will be assigned to ensure resident safety and nurse's core ability to identify, assess, develop, implement and revise necessary care plans for residents. Facility will continue to work with Human Resources Department to advertise, fill and/or create vacant positions to ensure a competent and adequate labor pool, and retention of existing staff. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in ensuring the importance of making resident-centered care a priority and participate in a monthly staffing focus meeting to review schedules, open shifts, recruitment, and retention practices. Input from direct care staff members will be included in the staffing meetings to gain insight on staffing. 3. Mandating policies were in place and staff were aware of the policies. All residents have the potential to be affected by this practice. All nursing staff will be reeducated regarding this policy. Facility will ensure that adequate staffing is available to meet the needs of all residents. Nursing staff will be assigned to ensure resident safety and nurse's core ability to identify, assess, develop, implement and revise necessary care plans for residents. Facility will work with Human Resources Department to advertise, fill and/or create vacant positions to ensure a competent and adequate labor pool, and retention of existing staff. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in ensuring	

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4 148	Continued From page 24 and there would be 5 CNAs for 41. I inherited this grid. I have 16 vents, 12 on A and 12 on B. We have been advertising. I had six openings for RNs and filled one. I have six licensed practical nurse positions to fill but we have not been able to fill those. DON shared the various advertising and recruitment scenarios but says filling positions has been a challenge.	4 148	the importance of making resident-centered care a priority and participate in a monthly staffing focus meeting to review schedules, open shifts, recruitment, and retention practices. Input from direct care staff members will be included in the staffing meetings to gain insight on staffing. The Director of Nursing or designee will be responsible for compliance with scheduling practices and policies. Monthly audits of nursing staffing schedules will be done to identify any trending problem areas. Staffing related trends will be reported to Quarterly QA Meeting. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will conduct random call light response audits weekly and monitor response times to assist in determining adequate staffing for resident census, on a weekly basis. Any problematic trends will be reported at the quarterly QA meetings for discussion. 11)1. Laundry contacted to ensure adequate PAR level of blankets and linens are available daily for all shifts. Staff to notify unit managers if daily delivery of blankets and linens is inadequate. Laundry will then be contacted for additional supplies as necessary. 1. Care plans and Activity Assessments for all residents at a sub-acute level of care will be reviewed and updated to meet the highest practicable physical, mental and psycho-social well being of each resident. Activity Department staffing will be evaluated to ensure that the activity	

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4 148	Continued From page 25	4 148	needs of all residents are met. 2. All residents with limited mobility, communication and cognition, based on the MDS have the potential to be affected. Care plans and Activity Assessments for all residents in the facility that are at risk for not having the highest practicable physical, mental and psycho-social well being met due to staffing will be reviewed and updated. 3. Monthly meetings will be held by Activity Coordinator and Activity Staff to review activity care plans and participation records for these identified residents. Any changes to individual activity care plans will be made at this time. 4. An audit tool will be developed to monitor the activity involvement for identified residents. Quarterly audits of activity involvement will be done and reported to Quarterly QA Meeting.	
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;	4 149		2/28/19

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4 149	Continued From page 26 (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 observations and interviews the facility failed to ensure that facility staff possess the competencies and skill sets necessary to provide nursing and related services to meet the resident's need safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being. Findings Included: 1) On 01/08/2019 at 12:28 PM interviewed the administrator (ADM) to investigate complaint (ACTS#6292), made to the state agency (SA) on 05/09/2018. The complainant reported that his mother (victim) was administered the wrong medications (meds) and sent to an acute hospital emergency department for treatment on 05/04/2018. According to the ADM, an agency nurse mistakenly administered meds that belonged to resident in bed (403C) to resident (victim) in bed (403B). On 05/04/2018 at 06:00 PM the resident (victim) was incorrectly administered: Atorvastatin 80 mg, Gabapentin 300 mg, Lorazepam 2 mg, Metoprolol 100 mg, Oxycodone 5 mg, Senna-S 8.6/50 mg, and Warfarin 5 mg. The resident was sent to an acute hospital	4 149	4149 1) 1. No corrective action could be accomplished for the resident found to be affected because specific resident is no longer present in the facility. Agency was immediately notified and caregiver is no longer assigned to facility. 2. Medication errors are an ongoing quality performance measure that are routinely identified and addressed if related to specific nurse practice error. Re-education and post-testing is given at that time. Performance improvement monitoring is enacted and tracked by DON and/or designee. 3. All LN staff will follow correct medication administration protocol as per their license requirements. Monitoring and review by contract Pharmacy additionally assists with identifying areas of medication administration improvement and are followed up on immediately with identified staff. 4. All medication errors are tracked and reported monthly to Nursing Administration for quality assurance. Data is trended and reported at Quarterly QA Meeting.	

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4 149	Continued From page 27 emergency department (ED) by ambulance and arrived there at 08:39 PM. The ED progress notes documented that the resident (victim) was assessed, monitored and treated with 0.4 mg of Narcan. The resident had no hypotension, no bradycardia, no respiratory distress and vital signs remained stable. The resident (victim) was released from the ED on 05/05/2018 at 08:30 AM and brought back to the facility. The ADM stated that the resident was discharged on 05/31/2018 to family with homecare services after completing her short-term rehab stay at the facility and had no other adverse events after the above incident. On 01/14/2019 at 02:49 PM interviewed the ADM and DON and inquired if the facility developed a new process for orienting agency nurses to the facility. The ADM stated that agency nurses follow seasoned nurses for one shift in general. The agency that the nurse (perpetrator) came from was more problematic with med errors. The facility still uses the agency but now use nurses that are known to them. The facility made med errors a quality assurance (QA) project and the med error rate decreased from a high of 65 in 2015 down to 5 in 2017. The med error went back up to 21 in 2018 on the fourth floor due to the resident status mix of subacute and short-term rehab. The resident (victim) was on the fourth floor. 2) On 01/10/2019 at 10:03 AM observed two CNAs transfer R77 from the shower gurney back to bed. The R77's Foley catheter container was lying flat on the shower gurney to the left side of R77. The Foley catheter container had urine in it	4 149	2) 1. Direct care staff were re-educated regarding proper use of lift transfer and foley catheter care during transfers of Resident 77 and all residents potentially affected by this deficient practice.. 2. All residents with a foley catheter have the potential to be affected by this deficient practice. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in education for target skills related to foley catheter care.. 3. Skill competencies and performance evaluations will be reviewed and updated as needed. Competency and performance expectations will be initiated during new hire orientation, reviewed within 90 days, and annually thereafter. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in educating and training staff in target areas based on competency and performance reviews. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will monitor and audit skill competencies monthly for 6 months to target specific skills, on an as needed basis, and annually thereafter. Any problematic trends will be reported at the quarterly QA meetings for discussion. 3) 1. Direct care staff educated regarding insulin administration to Resident 77 and all residents receiving insulin via syringe. 2. All residents with insulin use have the potential to be affected by this deficient practice. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary	

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4 149	Continued From page 28 and was was placed into the Hoyer-lift sling next to R77. As one CNA operated the Hoyer-lift to transfer R77 back to bed, the other CNA grabbed a towel to catch the urine that began to leak from the sling. Inquired of the CNA whether the Foley catheter container should be lower than R77 and the CNA stated, "Yes, but we're transferring." Interviewed UM121 at the unit's nursing station and queried how Foley catheter system should be placed when transferring resident on shower gurney and Hoyer-lift. The UM121 stated that Foley catheter system should be hung to side of shower gurney and one CNA should be holding Foley catheter container when the resident is transferred in Hoyer -lift sling. Shared observations with UM121 and he stated that would talk to CNAs. 3) On 01/10/2019 at 12:50 PM observed RN4 administer insulin to R77. Observed that RN4 prepped the insulin 3 cc syringe for two units of insulin by pushing two units of air into the insulin bottle rubber stop and then pulling back two units of insulin. Followed RN4 to R77's bedside for insulin administration and RN4 removed the syringe cap and pushed out some insulin before administering to R77. Inquired of RN4 if that was the usual practice for insulin administration. RN4 stated that there was a small air bubble in the syringe and whether he injects subcutaneous (SQ) or intramuscularly need to ensure no air bubble in syringe. Inquired if R77 received the two units of insulin after RN4 pushed out some insulin with air bubble and he did not have an answer. The DON provided the policy and procedure for subcutaneous injections and there was no step in	4 149	team members will participate in ongoing education for target skill. 3. Skill competencies and performance evaluations will be reviewed and updated as needed. Competency and performance expectations will be initiated during new hire orientation, reviewed within 90 days, and annually thereafter. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in educating and training staff in target areas based on competency and performance reviews. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will monitor and audit skill competencies monthly for 6 months to target specific skills, on an as needed basis, and annually thereafter. Any problematic trends will be reported at the quarterly QA meetings for discussion. 4) 1. Facility has released DON due to performance related deficiencies and concerns brought to the Administrator by staff and other nursing managers. Nursing Managers and Administrator to ensure all training, education, staffing, policies and procedures are adhered to according to all licensing operation requirements. All residents have the potential to be affected by the deficiency of sufficient nursing staff. A review of staffing assignments will be performed to ensure resident safety and needs are being met in a timely and appropriate way and allowing for nursing core abilities to identify, assess, develop, implement and revise necessary care plans for residents needs. All nursing staff reminded that resident care is priority,	

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4 149	Continued From page 29 the procedures to remove air bubble from the syringe for SQ injections.) On 01/14/19 at 09:00 AM, an interview with the DON was done. She acknowledged they have had staffing concerns and worked with adding an additional agency to fill the shifts. The DON acknowledged the fourth floor nursing unit, "because of subacute, our staffing is done differently there," but could not elaborate on how it is done differently to ensure the residents' care needs are being met on all shifts. In addition, the DON was vague in her responses to various questions such as what her process was to ensure the residents were being assessed and care plans were being developed. The DON said she has lost "old timers, I have 100% change in my nursing leadership." The DON referenced a process using a reference book for her new unit managers to use, but confirmed she has not done any training for her nursing staff about, "this guide, that relates specifically to long term." The DON further said for their baseline care plans, "it was a product" she pushed forward, but other administrative staff did not agree with it so they are deadlocked over it. Hence, the baseline care plans nor their care plan policy have been updated to reflect the new regulatory requirements and to provide guidance to their nursing staff.) The facility failed to provide no less than twelve hours of in-service education for every nurse aide employed by the facility. There were	4 149	resident call lights should be answered in a timely manner, resident treatment and services completed per order and care plan, care plans and care interventions documented appropriately and resident's preferences and choices supported. 2. Facility will ensure that adequate staffing is available to meet the needs of all residents. Nursing staff will be assigned to ensure resident safety and nurse's core ability to identify, assess, develop, implement and revise base line and all necessary care plans for residents. Facility will continue to work with Human Resources Department to advertise, fill and/or create vacant positions to ensure a competent and adequate labor pool, and retention of existing staff. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in ensuring the importance of making resident-centered care a priority and participate in a monthly staffing focus meeting to review schedules, open shifts, recruitment, and retention practices. Input from direct care staff members will be included in the staffing meetings to gain insight on improving staffing. 5) 1. Facility will identify and have employees with incomplete mandatory inservice records come in to complete all in-service requirements including but not limited to the dementia care education module. Staff identified as not completing required in-service education modules will not be scheduled to work shifts until education is appropriately completed and	

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4 149	Continued From page 30 seven CNAs who did not meet this requirement. This included various topics, such as one for dementia care for the August 2018. This topic was not completed by these seven CNAs (refer to F730).) Review of R159's, R111's and R109's baseline care plan status revealed licensed staff failed to develop and implement baseline care plans (comprehensive care plans were developed in lieu of them), yet not within 48 hours of admission, and failed to ensure written summaries were provided to them and/or their representative (refer to F655).) Review of R33's and R35's comprehensive care plans revealed a failure to to ensure each resident's highest practicable physical, mental, and psychosocial well-being was provided as resident-centered care plans were not developed for the R33's limited range of motion (ROM) and R35's bruise and limited ROM (refer to F656). A family (F) member 1 for R35 said the facility's staffing was "different now" with a lot of agency staff. F1 said if she did not come to feed R35, she was not assured the staff would be able to feed R35 timely because there were many residents who needed to be assisted with not enough staff. F1 said with the change in staffing, this administration has been "different, just different," but did not elaborate further.) R20 was identified with recurrent urinary tract infections (UTI) and recently started on an antibiotics for eight weeks for a UTI. 01/09/19 09:35 AM I asked her if she had any problems with her shi-shi or peeing at this time, and she said no, nothing. I'm fine. Yesterday she said something	4 149	recorded. 2. All residents with dementia have the potential to be affected by this deficient practice. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in education for in-service requirements. 3. Monthly education modules will be offered to all staff. All staff is required to attend and maintain their educational requirements for continued work schedules and employment. 4. Monthly audits of education records will be conducted by Administrator and/or designee and staff not meeting annual requirements will be immediately notified of their responsibility to complete necessary and outstanding inservice(s). Audits will continue to ensure 100 percent participation in education by staff. Audit data will be reported to Quarterly QA Meeting. 6) 1) 1. R159 comprehensive care plans reviewed and summary given to active resident. Care plans reviewed and added for insulin, diuretics, and blood thinners. Nursing staff and Agency staff educated to comprehensive/baseline care plans. 2. Baseline care plan will be completed for all future admissions and diagnoses and medications will be reviewed for care plan development. 3. Admission checklist modified to include initiation of baseline care plan. Developed new baseline care plan form and summary format. Created orientation checklist for agency to include care plans and skills.	

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4 149	Continued From page 31 was wrong with her but didn't know what it was while she was lying in bed with covers pulled up. Today, she was sitting up well for breakfast while in bed and alert, but pleasantly confused. Ate everything except for scrambled eggs. No overt signs of confusion or delirium. Record review shows she has abx trimethoprim-sulfa methoxazole 40/200 mg 1 tab po daily x 8 weeks for dx: recurrent UTI. 01/10/19 12:51 PM Res in room, appears comfortable. MD order 12/10/18 for urine culture & sensitivity 12/11/18 (dx: recurrent uti). 12/10/18 also order for Vit C 500 mg 1 tab po bid dx: supplement, 1/2 cup 120 cc decaf coffee in between meals (1000 & 1400), glucerna dm 120 cc 3x day w/meals. okay to start trial chopped diet. Vital signs record shows she's been afrebrile except on 12/11/18 temp was 99.0, but then after for the remainder of december and til 1/9 at 2300 no fever; other VSS. 01/11/19 10:41 AM Res wanted to eat breakfast, was sleeping up until this time. She agreed to be cleaned for peri care, but then said, oh i want to eat first though. Will return to observe peri care. Dxs incude: R hemiplegia, ischemic stroke, htn, hyperlip, dm2 with diabetic renal manifestations, CKD stage 4, dysphagia, Vit D deficiency, aphasia, thyroid nodule, recurrent uti, Annual MDS with ARD 10/19/18. BIMS 99 - unable to complete interview. Is total dependence with 1-2 person assist. For B&B,	4 149	Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in educating staff and monitoring care plan development on a weekly basis for 4 weeks, bi-weekly for 4 weeks, monthly thereafter and during care conferences. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will perform admission, monthly and quarterly audits. Any discrepancies will be resolved immediately. Any problematic trends will be reported at the quarterly QA meetings for discussion. 2) 1. R111 comprehensive care plans reviewed. Care plans reviewed and added for diuretic/swelling, portacath, colostomy and use of antibiotic. Summary unable to be given as resident is no longer present in the facility. Nursing staff and Agency educated to comprehensive/baseline care plans. 2. Baseline care plan will be completed for all future admissions and diagnoses and medications will be reviewed for care plan development. 3. Admission checklist modified to include initiation of baseline care plan. Developed new baseline care plan form and summary format. Created orientation checklist for agency to include care plans and skills. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in educating staff and monitoring care plan development on a weekly basis for 4 weeks, bi-weekly for 4 weeks, monthly thereafter and during care conferences.	

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4 149	Continued From page 32 she is always incontinent for urinary and bowel. No bowel toileting program. The CAA for urinary incontinence dated 10/26/18 shows she is incontinent of bowel and bladder function, on chronic use of pads and diaper. High risk for skin breakdown, and another UTI. There is a 10/18/18 care plan for potential for urinary tract infection r/t hx of utis, incontinence of bowels and most recent one is dated 12/17/18 for UTI to have resolved infection without severe complication over next 8 week (56 days). - episodic care plan in addition to the Oct 2018. Her 12/6/18 UTI showed large leukocyte esterase and many bacteria so reflex C&S done with final showing mixed flora and put on Trimeth/Sulfa; CBC WNL, December R arm cellulitis on Cephalexin 01/10/19 01:32 PM Cathy RNA shows her liquid intake and on blue paper for not meeting goal. So they are keeping eye on her, even from way back and was encouraged to drink every 2 hours and every 1 hour and nurse too, and we tried coffee, water according to diet because has DM, and she is the most for hydration risk for not meeting. 01/14/19 10:15 AM with cna marivic who is caring for the resident today. found res has just awoken and is now eating breakfast. May do the peri care later. 01/14/19 10:20 AM I asked the resident if she has any dysuria, pain, discomfort with peeing, and she said no, but I don't know. She appears to be in no significant	4 149	4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will perform admission, monthly and quarterly audits. Any discrepancies will be resolved immediately. Any problematic trends will be reported at the quarterly QA meetings for discussion. 3) 1. R109 comprehensive care plans reviewed. Summary unable to be given as resident is no longer present in the facility. Nursing staff and Agency educated to comprehensive/baseline care plans. 2. Baseline care plan will be completed for all future admissions and diagnoses and medications will be reviewed for care plan development. 3. Admission checklist modified to include initiation of baseline care plan. Developed new baseline care plan form and summary format. Created orientation checklist for agency to include care plans and skills. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in educating staff and monitoring care plan development on a weekly basis for 4 weeks, bi-weekly for 4 weeks, monthly thereafter and during care conferences. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will perform admission, monthly and quarterly audits. Any discrepancies will be resolved immediately. Any problematic trends will be reported at the quarterly QA meetings for discussion.	

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4 149	Continued From page 33 distress, alert but pleasantly confused. 01/14/19 10:43 AM peri care with marivic cna now. this is second change of morning. she will also get a shower this morning. res says yes, still wants to take nap. used cleansing foam; uses the spray foam first and wipe it twice, front to back, discard. this is first time working with her, but did not know she has hx of utis. important to know that? Said yes, because should she have changes on abx (said like mood/behavior), after this change, I told her I won't bother her because resident didn't even want to be changed now. So now she knows to check on her more with UTI. This is first time as agency cna to work with her and is solo on the unit today. Last week, she had the 2 days orientation. Marivic said during endorsement this morning, we just changed herdiaper and the cna said nothing to worry about her skin either. Nothing else. orientation - 2 days? Yes, and said good enough for her. palolo CHN only 4 hours.	4 149	7) 1) 1. R33 comprehensive care plans reviewed. Care plans added for Splint, Range of Motion and Restorative Nursing. Nursing staff, RNAs and Agency staff educated to care plan, restorative care flow record and initiating and updating care plans. 2. Director of Nursing, Nursing Supervisors, RNAs, Rehab and relevant Interdisciplinary team members to identify residents on splints/braces with Rehab collaboration and identify residents on RNA program with RNA collaboration. 3. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members to participate in educating all staff in initiation of Splint/ROM/RNA care plans, monitoring of restorative care flow record, and proper documentation and communication. Collaboration with Rehab for appropriate use and documentation for splints/braces when indicated. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will perform monthly audits during RNA/Rehab meetings. Any problematic trends will be reported at the quarterly QA meetings for discussion. 1. R35 comprehensive care plans reviewed. Bruise care plan reviewed and updated. Nursing staff educated to care plan initiating, completion and update practice. Feeding assignments and protocol reviewed with Charge Nurse and assigned staff to ensure residents receive timely and appropriate assistance with adl needs, including feeding assistance. Charge Nurse to assign staff and ensure	

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4 149	Continued From page 34	4 149	tasks are appropriately carried out. 2. Director of Nursing, Nursing Supervisors, RNAs, Rehab and relevant Interdisciplinary team members to identify residents on splints/braces with Rehab collaboration and ensure residents on RNA program, with RNA collaboration are receiving appropriate and timely services. 3. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members to participate in educating all staff in initiation of Splint/ROM/RNA care plans, monitoring of restorative care flow record, and proper documentation and communication. Collaboration with Rehab for appropriate use and documentation for splints/braces when indicated will be done as needed and reviewed during monthly Rehab and RNA meetings. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will perform monthly audits during RNA/Rehab meetings. Any problematic trends will be reported at the quarterly QA meetings for discussion. 8)1. Direct care staff were re-educated regarding UTI related care. All residents are potentially affected by this deficient practice.. 2. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in education for target skills related to UTI related care. 3. Skill competencies and performance	

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4 149	Continued From page 35	4 149	evaluations will be reviewed, updated and regulated. Competency and performance expectations will be initiated during new hire orientation, reviewed within 90 days, and annually thereafter. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in educating and training staff in target areas based on competency and performance reviews. Facility will work with Staffing Agencies to determine schedule adjustments to ensure adequate orientation periods for agency staff. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will establish a performance and competency checklist for all Agency staff to complete during their orientation schedules. Staff Agencies will be notified immediately if contract staff does not meet competency skills required. 4. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in evaluations for performance and competency weekly for one month after an Agency staff has completed orientation and on an as needed basis thereafter. Any problematic trends will be reported to Staffing Agencies and to the quarterly QA meetings for discussion.	
4 152	11-94.1-39(e) Nursing services (e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures.	4 152		2/28/19

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4 152	Continued From page 36 The policies and procedures shall include but not be limited to: (1) Written procedures for personnel to follow in an emergency including: (A) Care of the resident; (B) Notification of the attending physician and other persons responsible for the resident; and (C) Arrangements for transportation, hospitalization, or other appropriate services; (2) All treatment and care provided relative to the resident's needs and requirements for documentation; and (3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized This Statute is not met as evidenced by: Based on interview and record review (RR), the facility failed to accurately document as needed (prn) medications in the correct space provided in the "Medication Administration Record" (MAR) for R49 and R93 of 38 residents selected for review. This deficient practice has the potential to cause serious medication errors for the residents. Findings Include: 1) On 01/10/2019 at 08:29 AM, Interview with RN10 who stated R49 was given Oxycodone	4 152	4152 1) 1. 1. Medication administration record reviewed. Nursing staff and Agency were immediately notified and re-educated to ensure proper documentation regarding PRN medications on MAR. Meeting held with contract pharmacy to adress issues identified and need for adjustments to MAR forms for consistency and accuracy of PRN medication administration documentation. Contract pharmacy has created new prn medication MAR templates to ensure licensed staff have adequate and appropriate space for documentation of medication	

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4 152	Continued From page 37 2.5mg by mouth prn for pain on 12/30/2018 but in the MAR it was documented under the column for 12/01/2018. When queried by surveyor, RN10 stated that's just the way they do. On 01/10/2019 at 08:40 AM, RR of R49's MAR showed Oxycodone 2.5mg prn for pain was given on 12/30/2018 but was documented under 12/01/2018. Acetaminophen (Tylenol) 325mg 2 tabs by mouth prn for pain was given on 01/05/2019 but was documented under 12/01-02/2018. 2) On 01/11/2019 at 09:27 AM, RR of R93's MAR showed Acetaminophen (Tylenol) 325mg 2 tabs by mouth prn for pain was given on 01/07/2019 but was documented under 01/01/2019. On 01/11/2019 at 10:17 AM, Interview with UM115 who stated they are working on giving the staff in-service on better documentation, more accuracy and consistency in monitoring for pain. On 01/11/2019 at 02:40 PM, Interview with Administrator who stated she has researched it with long time staff regarding medication documentation in the MAR's. Administrator stated the staff told her they was told to do it that way. Administrator was not able to say who told the staff to do that. Administrator said the staff stated when giving prn medications, they do not have enough room under the column of the date that the medication was given if the prn medication was given more than once. Administrator stated that's why the staff documented in the first open space farthest to the left. Administrator admitted	4 152	administration. 2. All residents have the potential to be affected by the MAR deficiency. All MARs are audited and monitored on a monthly basis to ensure the proper documentation of medication administration. 3. Director of Nursing, Nursing Supervisors and relevant Interdisciplinary team members will participate in educating staff regarding daily (all shifts) monitoring on MAR. MARs to be audited and monitored on a monthly basis by DON or designee and Pharmacy consultant. Pharmacy to be included in and participate in documenting recommendations related to and affecting MAR entries by Licensed staff. 4. Director of Nursing and/or designee will perform monthly audits. Any discrepancies will be resolved immediately. Any problematic trends will be reported at the quarterly QA meetings for discussion.	

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4 152	Continued From page 38 that was not good practice but at least she understands why the staff did it that way. Administrator said she will work on getting the MAR's fixed as soon as possible.	4 152		
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, interviews and record review, the facility failed to ensure it maintained and provided comfortable, hot showers for residents for one of the shower rooms they used on the nursing units. This deficient practice had the potential to affect other residents who preferred showers on the nursing units. Findings Include: During the Resident Council (RC) interview conducted on 01/09/2018 at 10:15 AM, three residents stated sometimes when they showered, the hot water during their showers would become cooler and would be uncomfortable. One resident (R) 16 stated, "I think the capacity of the water heater is not enough, when they turn on the shower, it's hot, then within 1 minute, it turns cold." R16 stated this happened again during his shower this morning.	4 269	4269 1. Plumbing contractor will repair and/or replace any malfunctioning hot water system components to ensure hot water temperatures are maintained within regulatory compliance standards. 2. Environmental Services Coordinator will inservice CNA staff as to correct use of water mixing valves in shower rooms. All CNA staff to be familiar with water temperature setting adjustments per resident individual bathing preferences. 3. Daily Log to be maintained by Maintenance Department of source water temperature. Daily random shower room check to be	2/28/19

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4 269	Continued From page 39 R16 resides on the second floor. R16 said he showers in both the A and B shower rooms, but that one of the shower rooms on their unit, "gets cold." R16 said he did not have a preference for a particular shower room; he showered in whichever one was available to his certified nursing assistant (CNA) during his shower days. R22, who also resides on the second floor stated the hot water temperature was okay for her, and since she was on the same floor as R16, the difference was probably because she was on the other side of the second floor nursing unit from R16. R159, who resides on the third floor, stated for her hot showers, "It starts off nice," but while showering, "It really cools off." R9, who resides on the fourth floor, also said the hot water on their floor got cold during a shower. R9 said when another resident was simultaneously being showered in the other shower rooms, that was when the hot water became cold. On 01/10/2019 at 08:28 AM, a review of the water temperature logs taken for the shower rooms was done. During an interview with the environmental services (ES) staff 1, he stated he checked the water temperatures of the three shower rooms, A, B and C, daily, on all three nursing units. The facility's "Daily Hot Water Temp Monitoring Log" revealed that ES staff 1 was alternately checking the hot water temperatures for shower rooms B and C, but omitted checking the hot water temperatures for the shower room A on the three units. ES staff 1 affirmed he only checked the cold water temperatures for the three "A" shower	4 269	done, per floor, by Maintenance Department, to ensure hot water temperatures are within regulatory compliance. 4. Maintenance Department Director will monitor and report any non/compliance with hot water standard to Quarterly Quality Committee.	

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4 269	Continued From page 40 rooms. ES staff 1 also said if he heard of any complaints about the hot showers being cold, he would check it right away and that he has checked shower room A for it. However, there was no documentation that this was done. The daily log showed for the three shower rooms on each nursing unit, a pattern existed whereby the "A" shower rooms were not checked for the hot water temperatures for October through December of 2018 and up to 01/10/2019. On 01/10/2019 at 08:52 AM, during an interview with the ES director, he verified ES staff 1 was supposed to check all shower rooms for the hot water temperatures and it was a random check. The ES director was unaware however, the "A" showers' hot water temperatures on the three units were not being checked as documented on the log, or that the hot water temperature became cooler during the showers. On 01/10/2019 at 09:21 AM, the ES director stated the CNAs will have to be re-trained to use a "knob" like a mixing valve during resident showers.	4 269		