

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2019
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NAME OF PROVIDER OR SUPPLIER HILO MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1190 WAIANUENUE AVENUE HILO, HI 96720
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4 000	<p>Initial Comments</p> <p>A licensure survey was conducted by the Office of Health Care Assurance on December 17, 2019 through December 20, 2019. The facility was found not to be in compliance with 42 CFR 483 subpart B. Survey census was 32.</p> <p>Facility Reported Incidents (FRIs) were investigated in conjunction with the licensure survey. The following FRIs were reviewed HI0007727 and HI0007799. The facility was found to be in substantial compliance with the requirements.</p>	4 000		
4 123	<p>11-94.1-27(12) Resident rights and facility practices</p> <p>Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including:</p> <p>(12) The right to be fully informed in advance about care and treatment and of any changes in that care and treatment and the right to participate in planning care and treatment, unless adjudged incompetent or incapacitated;</p> <p>This Statute is not met as evidenced by: Based on record review, staff interview, and review of policy, the facility failed to provide education regarding benefits and potential side effects for the Influenza Vaccination that was given to two Residents ((R) 15, 28) out of the seven residents reviewed. As a result of this</p>	4 123	<p>IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN</p> <p>R15 and R28 responsible party, Power of</p>	1/16/20

Office of Health Care Assurance LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 01/16/20
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4 123	<p>Continued From page 1</p> <p>deficient practice, the two residents and/or their representatives was not given the opportunity, or even the discussion, of minimizing the risk for acquiring, transmitting, or experiencing complications from the Influenza vaccination.</p> <p>Findings Include:</p> <p>1. During a review of the immunization record for R15, it was noted that R15 received the Influenza vaccination on 10/10/19. However, after further record review, there was no documentation noted that the resident and/or resident's representative was provided education regarding the benefits and potential side effects of the influenza vaccination.</p> <p>On 12/20/19 at 12:30 PM, the Director of Nursing (DON) was queried and subsequently provided a consent form for R15 on the Influenza immunization. However, the consent form was for the previous flu season 2018-2019. There was no consent form provided for the current year 2019-2020.</p> <p>2. During a review of the immunization record for R28, it was noted that R28 received the Influenza vaccination on 10/04/19. However, after further record review, there was no documentation noted that the resident and/or resident's representative was provided education regarding the benefits and potential side effects of the influenza vaccination.</p> <p>On 12/20/19 at 12:30 PM, DON was queried and subsequently provided a consent form for R28 on the Influenza immunization. However, the consent form was for the previous flu season 2018-2019. There was no consent form provided for the current year 2019-2020.</p>	4 123	<p>Attorney and/or Guardian provided with education regarding Influenza and Pneumococcal Immunizations.</p> <p>Audit completed on Influenza and Pneumococcal consents and education for all residents.</p> <p>MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE</p> <p>Influenza and Pneumococcal Immunization packets will be developed that will include both consents and education.</p> <p>Copies of completed consents will be filed in resident physical charts and original will be sent for scanning to HIM (Health Information Management).</p> <p>MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS</p> <p>Director of Nursing and/or designee will provide a monthly report during the time period of October 1st through March 31st of completed Influenza and Pneumococcal Immunization consents and education and will be submitted to Administrator for review and included in QAPI meeting to ensure on-going compliance.</p>	

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4 123	Continued From page 2 A review of the facility policy titled Influenza and Pneumococcal Vaccination Protocol for Acute Care Inpatients and Long Term Care Residents stated the following: Policy, A. Hilo Medical Center Registered Professional Nurses (RPNs) and Licensed Practical Nurses (LPNs) are authorized to give the influenza and/or pneumococcal vaccine to Hilo Medical Center patient and residents, who meet the criteria established by the Centers for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP). B. ...the nurse screens the patient using the Vaccine Consent/Documentation Tool. Procedure, A. Identify vaccine recipients with the criteria on the Vaccine Consent/Documentation Tool. The form lists the contraindications and timeframes for giving vaccine. As previously mentioned, there was no consent form provided for R15 and R28.	4 123		
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.	4 136		1/16/20

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4 136	<p>Continued From page 3</p> <p>This Statute is not met as evidenced by: Based on observations, record reviews and interviews with resident and staff members, the facility failed to: provide a bowel regimen for a resident to address constipation related to the routine and pro re nata (prn) use of opioid medication for pain management for 1 (Resident 18) of 1 residents sampled; prevent an avoidable facility-acquired pressure ulcer, resulting in a development of a Stage 2 pressure ulcers to the coccyx and right lateral knee; and provide nursing professional standard of care for Resident (R)89's peripherally inserted central catheter (PICC), placing residents at risk for infection.</p> <p>Findings include:</p> <p>1) On 12/17/19 at 02:07 PM, an interview was conducted with Resident (R)18. R18 was asked whether he/she has constipation, R18 responded that he/she takes pain medication which results in constipation. R18 confirmed that sometimes he/she will go without a bowel movement for more than three days. Initially, R18 reported that he/she fixes it on his/her own; however, later reported that medication is provided.</p> <p>On 12/18/19 at 02:58 PM, a record review was done. R18 was admitted to the facility on 08/25/17 with the following diagnoses: congestive heart failure; chronic atrial fibrillation; chronic obstructive pulmonary disease; chronic kidney disease, Stage III; and diabetes mellitus, non-insulin dependent.</p> <p>A review of the annual Minimum Data Set with assessment reference date of 10/28/19 documents R18 yielded a score of 15 (cognitively</p>	4 136	<p>IDENTIFY OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN:</p> <p>Resident 18 Miralax order was clarified to include medication administration time (EVENING SHIFT)</p> <p>An Audit was completed for all residents in facility for Bowel and Bladder management and clarified medication administration times.</p> <p>Education for nursing staff on Bowel and Bladder management monitoring will be completed by January 31, 2020.</p> <p>MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE:</p> <p>Bowel and Bladder management monitoring will be initiated for each resident upon admission.</p> <p>A Bowel and Bladder management report has been developed to track residents who have not had a bowel movement in 48 hours. This report will be printed out daily by the Charge Nurse and/or designee and provided to Team Leaders.</p> <p>MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS:</p> <p>Director of Nursing and/or designee will</p>	

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4 136	<p>Continued From page 4</p> <p>intact) upon administration of the Brief Interview for Mental Status. R18 requires extensive assist with one personal physical assist for toilet use. The resident is continent of bowel and bladder. R18 was not coded for constipation. In the medication section, R18 was documented as receiving opioid medications for pain daily in the last seven days.</p> <p>A review of the physician's order found prescription for: senokot tablet (laxative), 8.6 mg daily; docusate sodium (stool softener), 100 mg. every morning; miralax powder, 17 gm every 48 hours as needed for constipation with a start date of 10/16/19; oxycodone HCl, 5 mg every four hours for pain, prn; oxycodone HCl, 10 mg every four hours for pain, prn; and routine oxycodone HCl 10 mg. twice a day at 08:00 AM and 05:00 PM.</p> <p>Further review of the facility's intake and output log found the tracking in the electronic health record (EHR) which documents the following: continent of bowel movement (#); incontinent of bowel movement (#); and bowel movements (#). The EHR documents R18 did not have bowel movement from 12/04/19 through 12/06/19. R18 was documented with 0 (zero) for continent of bowel movement and incontinent of bowel movement and no documentation for number of bowel movement.</p> <p>A request was made to review the resident's frequency of bowel movement. The facility provided a vertical report entitled "Continent of BM (#)". The review found R18 did not have bowel movement from 11/19/19 through 11/20/19; 11/28/19 through 11/29/19; and 12/09/19 through 12/10/19. This report did not indicate R18 did not have a bowel movement from 12/04/19 through</p>	4 136	<p>review and confirm Bowel and Bladder management monitoring initiated for each resident upon admission for 90 days or until 100% compliance is met.</p> <p>Director of Nursing and/or designee will provide monthly Bowel and Bladder management report to Administrator for review and included in QAPI monthly meeting to ensure on-going compliance.</p>	

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4 136	<p>Continued From page 5</p> <p>12/06/19, it is documented R18 was continent of bowel movement under the heading of result as 1 (one). The intake and output documented in the EHR did not match the filtered report provided by the facility.</p> <p>On 12/19/19 at 01:15 PM, an interview was conducted with Licensed Nurse (LN)6. Inquired when is the prn of miralax for constipation is provided. LN6 responded when the resident does not have a bowel movement on the second day. LN6 further clarified the nurses keep track of residents' bowel movement by shift reports. A review of the physician order with LN6 confirmed the order does not indicate when to give the prn (beginning of second day or the end of second day).</p> <p>On 12/19/19 at 02:53 PM, an interview was conducted with the Director of Nursing (DON) and Resident Assessment Coordinator (RAC). A review of the documentation provided by the facility confirmed the aforementioned time periods when the resident did not have a bowel movement. Requested documentation that a prn of miralax powder was provided. There was no documentation of administration of miralax. The RAC reported, the resident may have refused the prn. Further requested documentation of the refusal. The RAC confirmed there is no documentation of resident's refusal for prn of miralax during the aforementioned periods.</p> <p>2) On 12/18/19, a review of the facility's "Resident Census and Conditions of Residents" (CMS-672) found documentation of one resident with pressure ulcer (excluding Stage 1). The Facility Matrix provided by the facility on the morning of 12/17/19 did not document Resident (R)2 has pressure ulcer.</p>	4 136		

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4 136	<p>Continued From page 6</p> <p>R2 was admitted to the facility on 09/09/19. Diagnoses include: coronary artery disease; history of lung cancer; and cerebrovascular accident. Observation of the resident during the initial tour of the facility on 12/17/19 found R2 asleep in bed with noted right below knee amputation.</p> <p>On 12/20/19 at 07:57 AM, a record review was done. A review of the physician's order dated 12/10/19 found the following: coccyx wound, apply sensicare barrier cream twice daily and prn; reduce pressure on bony prominences; bed cradles; heel and elbow protectors; elevate affected extremity when appropriate; and maintain limbs in functional alignment.</p> <p>R2 has a care plan to maintain skin integrity, prevent skin breakdown. The following care plan revisions include: 11/07/19 - monitor for presence of edema; 11/25/19 - use skin sleeves to bilateral arms for skin protection and do treatment to my right lateral knee; 12/09/19 - turn me very hour when in bed, continue to do skin check routinely, and notify physician/wound nurse of significant findings; and 12/09/19 - continue to encourage to increase fluid intake as tolerated and if not indicated.</p> <p>On 12/20/19, observation at 09:40 AM found R2 asleep in bed (air mattress), the resident was placed on his/her back with legs raised behind the knees. At 10:10 AM, resident was observed in bed, in the same position. The hospice worker was visiting the resident.</p> <p>A request was made for documentation of skin assessments. On 12/20/19 at 09:43 AM, the facility provided documentation of the progress</p>	4 136		

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4 136	<p>Continued From page 7</p> <p>notes related to the R2's pressure ulcers. The note for 10/30/19 documents R2 has a prosthesis for the right leg which he/she applies independently. A Stage 2 pressure ulcer developed as the resident was placing a sock on before applying the rubber cushion for the prosthesis.</p> <p>The skin and weight note dated 10/31/19 documents a pressure ulcer to right lateral knee measuring 1 cm x 1 cm. At this time Glucerna was ordered to increase R2's protein intake. Also, R2 was willing to add Arginaid (protein supplement) to his/her diet. Subsequent note on 11/07/19 documents no change to measurement of the wound. R2 was consuming the Glucerna and Arginaid to promote wound healing. R2 also documented with pneumonia. A nursing note on 11/09/19 notes wound bed is pink with contracted edges and minimal sanguineous draining with no signs and symptoms of infection. The use of duoderm was discontinued and silvercel with kerrafoam dressing was initiated. The subsequent assessment notes on 11/13/19 a decrease in the wound from 1 cm x 1 cm to 1 cm x 0.8 cm.</p> <p>The note on 11/28/19 found R2 with recent decline in conjunction with changes in mental status (more confused and disoriented). The note on 12/03/19 documents an increase in measurement from 1.0 cm x 0.8 cm to 1.5 cm x 1.0 cm.</p> <p>An alert charting for 12/07/19 notes R2 with an open area to the coccyx measuring 1.2 cm x 0.8 cm. The wound was covered with foam dressing and sensicare was applied. The plan was to reposition every two hours and to get an order for low air loss mattress. The assessment for</p>	4 136		

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4 136	<p>Continued From page 8</p> <p>12/19/19 notes R2 has two pressure injuries: Stage 2 to right lateral knee and Stage 2 to coccyx. The injury to the right lateral knee now measures 1.0 cm x 0.4 cm and the injury to the coccyx was 0.9 cm x 0.4 cm.</p> <p>On 12/20/19 at 10:13 AM, an interview was done with Licensed Nurse (LN)6. LN6 reported R2 has been experiencing a decline. LN6 also reported R2 was applying the prosthesis independently and upon discovering the application was wrong, the resident was re-educated. LN6 reported the injury to the right lateral knee started as a skin abrasion on 10/16/19 and was treated as an abrasion. Inquired whether weekly skin checks would find any changes to residents' skin to indicate possible skin breakdown. LN6 further explained R2 used to be very active and independent with hygiene care and recently has been more dependent on staff. LN6 responded the weekly skin check would indicate changes and maybe R2's skin breakdowns may have been identified before breaking down to a Stage 2 pressure ulcer. LN6 also reported R2 is being admitted to hospice.</p> <p>On 12/29/19 at 10:43 AM, an interview and concurrent record review was done with the Director of Nursing (DON). A review of the weekly skin assessments was done with the DON. The Stage 2 pressure ulcer to the right lateral knee was first documented on 10/09/19. The Advanced Practice Registered Nurse (APRN) was notified and ordered to apply bacitracin every day for four days. On 10/19/19, R2 went home for an overnight trip. Subsequently on 11/07/19, R2 was sent to the emergency department. The documentation up to 10/21/19 refers to the wound as an abrasion. A referral to the wound as a pressure injury was first documented on 10/31/19</p>	4 136		

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4 136	<p>Continued From page 9</p> <p>as a Stage 2 pressure ulcer.</p> <p>A review of the weekly skin assessments in December prior to the identification of a Stage 2 pressure ulcer to the coccyx (12/07/19) documents no skin issues. The DON reported R2 is declining and has been referred to hospice. The DON recalled prior to the breakdown of the coccyx (12/07/19), R2 went home from 11/01/19 through 11/03/19 for a visit.</p> <p>3) Resident (R)89, admitted on 12/13/19, was receiving intravenous (IV) antibiotic (piperacillin tazobactam) through a peripherally inserted central catheter (PICC).</p> <p>On 12/17/19 at 11:44 AM, licensed nurse (LN)5 prepared to administer intravenous medication for Resident (R)89. Observed the PICC dressing was not labeled, documenting the date, time, and staff that last changed the PICC dressing. LN5 confirmed the PICC dressing should have been labeled with the date, time, and staff initials. Additionally, LN5 confirmed there was no documentation in R89's medical record of the last date the PICC dressing was changed.</p>	4 136		
4 148	<p>11-94.1-39(a) Nursing services</p> <p>(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.</p>	4 148		1/16/20

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4 148	<p>Continued From page 10</p> <p>This Statute is not met as evidenced by: Based on interviews with residents, the facility failed to ensure the provision of sufficient nursing staff to provide services to assure residents maintain their highest practicable physical and psychosocial well-being.</p> <p>Findings include:</p> <p>1) On 12/18/19 at 10:00 AM, a confidential interview was done with ten resident council representatives that were invited to participate by the facility staff. The representatives reported staff members will respond to their call light right away; however, they are told they have to wait five to ten minutes as the staff member is providing care for another resident. Three residents reported there has been occasion where they had to wait for 30 minutes. One resident reported this usually occurs during the night shift. And another resident commented that he/she doesn't want to ask for help during the shift change.</p> <p>2) On 12/17/19 at 01:55 PM, a confidential interview was done with a cognizant resident (the resident yielded a score of 15 on the Brief Interview for Mental Status, which indicates the resident is cognitively intact). The resident reported there are three shifts and identified the 03:00 PM to 11:00 PM as not having enough staff members to provide care. The resident shared that the call light is pressed, the staff member responds, turns off the light, tells you they are busy and will come back. The resident further reported, the call light is being pressed for assistance for repositioning, bathroom and transferring in and out of bed; however, acknowledged that the staff members are run down.</p>	4 148	<p>IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN</p> <p>A review of the staffing schedules was conducted for the previous quarter which does not support the notion of insufficient staffing however, residents' perceptions of sufficient staffing maybe influenced by the staffing response to call lights therefore, plan of correction will focus on call light response time.</p> <p>Resident Council Agenda revised to address Call Lights for each shift to ensure specific interventions for each shift are provided.</p> <p>MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE</p> <p>Call Light Focus Rounds will completed for each shift weekly and will be submitted to Director of Nursing and/or designee for review.</p> <p>MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS</p> <p>Completed Focus Rounds will be submitted to Administrator for review and included in QAPI monthly meeting to ensure on-going compliance.</p>	

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NAME OF PROVIDER OR SUPPLIER HILO MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1190 WAIANUENUE AVENUE HILO, HI 96720
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4 159	<p>11-94.1-41(a) Storage and handling of food</p> <p>(a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions.</p> <p>(1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and</p> <p>(2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage.</p> <p>This Statute is not met as evidenced by: Based on observations, staff interview, and review of records, the facility failed to 1. Maintain a safe refrigerated food storage, and 2. Maintain water temperature records for the manual dishwashing station.</p> <p>Findings Include:</p> <p>1) During an initial tour of the kitchen on 12/17/19 at 09:50 AM, the walk-in refrigerator (GC14) was noted to have employee food stored on one of the shelves. The stored food was not labeled, not dated, and not being monitored.</p> <p>The Food Service Manager (FSM), who accompanied the initial tour, was queried about the stored food and acknowledged that the food was not labeled, not dated, and not being monitored.</p> <p>2) During a follow up visit to the kitchen on 12/19/19 at 09:59 AM, FSM stated that their dishwashing machine had recently broken down</p>	4 159	<p>IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN</p> <p>On 12/17/19 unlabeled, undated food in walk-in refrigerator was removed.</p> <p>On 12/19/19 Dietary staff educated on Manual Warewashing procedure.</p> <p>MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE</p> <p>Food Service Manager (FSM) and/or designee will provide daily checks of walk-in refrigerators.</p> <p>Dish machine out of service: Manual Warewashing Log will completed daily when manual warewashing procedure is in place.</p>	1/16/20

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4 159	<p>Continued From page 12</p> <p>and they were manually washing all the dishes. FSM explained the details of their manual washing process. However, upon review of records the facility had not recorded and/or maintained the water temperature for their washing since they started the manual washing process.</p> <p>On 12/19/19 at 11:00 AM, the FSM acknowledged that the facility had not recorded and/or maintained the water temperature for their manual washing process as previously mentioned. FSM actually created a new updated manual washing log which included the missing washing temperatures.</p>	4 159	<p>MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS</p> <p>Food Service Manager (FSM) and/or designee will provide monthly refrigerator reports to Administrator for review and included in QAPI meeting to ensure compliance.</p> <p>Food Service Manager (FSM) and/or designee will provide monthly report of Manual Warewashing Log and status of equipment regarding repairs/replacements.</p>	
4 197	<p>11-94.1-46(n) Pharmaceutical services</p> <p>(n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to discard an expired medication on 1 of 3 medication carts.</p> <p>Findings include:</p> <p>On 12/19/19 at 12:55 PM, an inspection of the medication cart was done with Licensed Nurse (LN)6. The observation found one bottle of polyethylene glycol which was not labeled with an open date. LN6 found the pharmacy label which documented an expiry date of 11/19. The licensed nurse reported this medication will be discarded.</p>	4 197	<p>IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL BE TAKEN</p> <p>Identified expired medication(s) were immediately discarded according to the "Outdated and Unusable Drugs" policy and procedure on 12/19/19.</p> <p>Licensed nursing staff will be re-educated on policies and procedures "Pharmerica: Medication Discontinuation and Destruction" and "Outdated Unusable</p>	1/16/20

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4 197	Continued From page 13	4 197	<p>Drugs" and completed by January 31, 2020.</p> <p>MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE</p> <p>Licensed nursing staff will complete medication cart audit form each shift and will report to Charge Nurse the findings.</p> <p>MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS</p> <p>Director of Nursing will complete weekly audits to ensure completion of medication cart forms.</p> <p>Director of Nursing and/or designee will provide medication cart audit report to Administrator for review and include in QAPI monthly meeting to ensure on-going compliance.</p>	
4 203	<p>11-94.1-53(a) Infection control</p> <p>(a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste.</p> <p>This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain a sanitary environment and failed to prevent the development and</p>	4 203	<p>IDENTIFYING OTHER RESIDENTS HAVING POTENTIAL TO BE AFFECTED, AND WHAT CORRECTIVE ACTION WILL</p>	1/16/20

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4 203	<p>Continued From page 14</p> <p>transmission of communicable diseases and infections as evidenced by the following: canister of beneprotein powder had a plastic measured cup (scoop cup) that was stored in the powder for multiple use; and a pad on the shower gurney had multiple tears and cracks, resulting in permeability of the plastic covering and allowing liquids/fluids to seep into the padding and resurface when weight is applied.</p> <p>Findings Include:</p> <p>1) On 12/20/19 at 09:47 AM, during an observation of the medication cart on the North Wing, a 6-8 ounce canister of Beneprotein powder was noted to have the scoop cup stored in the powder. Registered Nurse (RN) 23, who accompanied this observation, was asked about the scoop cup. RN23 stated that multiple hands would grab the scoop cup, but there was no procedure to ensure the cup was either sanitized or any procedure to prevent the spread of infections. RN23 further stated that the facility had most recently been using single use packets and wasn't sure when they switched to using the canister.</p> <p>2) On 12/18/19 at 11:45 AM, observation of the shower room was done with Certified Nurse Aide (CNA)8. The observation found a shower gurney with a blue padding insert. The blue pad had cracks in the raised area under the head and around the drainage holes. Inquired how is the pad sanitized, CNA8 responded the pad is washed down after use and sprayed with a sanitizing solution. Initially CNA8 stated the residents are placed directly on the plastic padding; however, after discussion that the plastic covering was now permeable, the CNA reported a towel is placed on the padding.</p>	4 203	<p>BE TAKEN</p> <p>Identified Shower Gurney with compromised pad was disposed and replaced with new Shower Gurney pad.</p> <p>Bene-Protein powder container replaced with Bene-Protein individual packets.</p> <p>MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE</p> <p>Shower equipment will be monitored and assessed quarterly and as needed to identify any issues.</p> <p>MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS</p> <p>Director of Nursing and/or designee will provide quarterly report for shower equipment to Administrator and included in QAPI meeting to ensure on-going compliance.</p>	

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