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	125065	A. BUILDING: _____ B. WING _____	02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HILO REHABILITATION & NURSING CENTEF	563 KAUMANA DRIVE HILO, HI 96720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	Initial Comments A re-licensing survey was completed on 02/07/20. The facility had a census of 77 residents.	4 000		
4 115	11-94.1-27(4) 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 request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observation and interview with residents, the facility failed to promote care for residents in a manner that enhances each resident's dignity as evidenced by providing a resident's meal on a plastic bag during dining; a staff member talking about the resident in the resident's presence; and a resident with an uncovered catheter bag in the presence of other residents. Findings include: 1) On 02/04/20 at 12:00 PM observed residents consuming lunch in the dining room. CNA1 was observed to bring R18's tray to the table. The CNA was heard stating she would check, the CNA was observed to remove the plate cover and	4 115	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Upon notification nursing staff involved were immediately in-serviced on the proper procedures for maintaining resident dignity during mealtimes. R#40 and R#41	3/24/20

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4 115	Continued From page 1 engaged in conversation with the resident. R18 could be heard saying, that he/she told them one hundred times, CNA1 then gave R18 the bowl of fruit then placed the lunch tray on the counter. R18 was asked what happened to his/her lunch, R18 replied that she/he asked for a tuna sandwich and was given egg salad. Later CNA1 was observed to bring a tuna sandwich which was cut into four pieces in a plastic bag to the resident. The CNA tore open the plastic bag and placed it on the resident's placemat. R18 ate his/her sandwich out of the plastic bag. On 02/05/20 at 11:30 AM an interview was conducted with four resident council representatives. The observation during the lunch meal was shared with the residents. Three of the four residents reported they would have preferred for the sandwich to be served on a plate. 2) Cross Reference F684. On 02/04/20 at 10:15 AM, R40 was observed with Registered Nurse (RN)1 pushing the resident in the wheelchair. The RN reported the two cups on the resident's bedside table were thrown out. As RN1 continued pushing R40 in the wheelchair, RN1 added that R40 has been refusing to take his/her medication and has been temperamental so they are going to have a meeting. 3) A record review documented Resident (R)41 was admitted on 10/10/19, diagnosed with: Cancer; Metabolic Encephalopathy; TBI without loss of consciousness; Hypernatremia; Dehydration; Kidney failure; Malignant neoplasm of the prostate; Cognitive communication; Muscle weakness; Aphasia; Spondylosis, Lumbar region; Malignant neoplasm of the vertebral column; Hypocalcemia; Retention of urine; Colostomy	4 115	were provided a Foley catheter dignity bag for use in common areas. 2. Identification: An audit was conducted to assure residents receive care in a manner that enhances their dignity by receiving meals on a plate and proper foley catheter dignity bag use in common areas. Appropriate follow up initiated based on audit results. 3. System Change: Nursing staff has been in-serviced on the proper procedures for serving residents meals in the dining room, ensure residents with indwelling catheters are provided a dignity bag in common areas, and also ensure they engage in respectful and appropriate conversations about the residents. 4. Monitoring: Routine audits ensuring that meals are provided in a manner that enhances the residents' dignity and that dignity bags are in place for those residents with Foley catheter use. Results of the audits will be reported to the QA committee for further follow up as indicated. DON and/or designee Corrective action completion date: 3/24/2020	

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4 115	Continued From page 2 status; and mild protein malnutrition. At the time of the survey (2/4- 7/20), R41 had just recently completed a round of oral chemotherapy treatment. R41 currently has a Foley catheter and an ostomy bag. Review of R41's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/29/19 documented R41's Brief Interview for Mental Status (BIMS) score was 1, indicating severe cognitive impairment. R41 requires the use of a mechanical lift and is totally dependent on staff for all transfer needs and requires a 2+ person physical assist, 1 person physical assist for locomotion in a wheelchair (unable to wheel self). R41's speech is unclear (slurred or mumbled words), sometimes able to understand (responds adequately to simple, direct communication only) of expressed ideas and wants (verbal and non-verbal), and rarely/never able to understand verbal content. On 02/05/20 at 09:21 AM, observed R41 participating in morning exercise and his catheter bag was not covered. The catheter bag was filled with approximately 220 milliliters of light yellow urine. More than 10 other residents were a part of the morning exercise group, along with 2 activity staff. Certified nurse assistant (CNA)8 and Licensed Nurse (LN)10 confirmed the catheter bag should have been covered to maintain R41's dignity.	4 115		
4 120	1-94.1-27(9) 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,	4 120		3/24/20

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4 120	Continued From page 3 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: (9) The right to names, addresses, and telephone numbers of pertinent resident advocacy groups; This Statute is not met as evidenced by: Based on resident interview and observation, the facility failed to ensure posting of the names, addresses (mailing and email) and telephone numbers of all pertinent State agencies and advocacy group (State Survey Agency, adult protective services, resident advocacy groups, home and community based services, and the Medicaid Fraud Control Unit in a form and manner which is accessible and understandable to residents and/or resident representatives. Findings include: On 02/05/20 at 11:30 AM the resident council interview was conducted with four residents. The residents were asked whether they know where the ombudsman contact information is posted. None of the participating residents were aware of the posting. Observation on 02/06/20 found a posting located across the kitchen in the hall which provided information of the contact information for the long-term care ombudsman. Although this information was posted, the posting was placed high on the board which would make it difficult for some residents to see if they are seated in a wheelchair. Another posting was found in the lobby of the facility. The posting included the long-term care ombudsman information; however, this information was also placed high on the board which would make it	4 120	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate Action: Upon notification of the deficient practice the pill cutter was cleaned appropriately. 2. Identification: An audit was conducted of medicine cart pill cutter cleaning and cleanliness to assure no deficient practices. Appropriate follow up initiated based on audit results. 3. System Change: Licensed staff will be in-serviced on ensuring the pill cutter/crushers are clean after use. 4. Monitoring: The facility will conduct random audit	

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4 120	Continued From page 4 difficult for residents to see if they are seated in a wheelchair. Further observations found postings of resident rights in the resident's rooms. The placement of the postings was inconsistent, some rooms had the posting next to the wash basin and other rooms had the posting above the paper towel dispenser (too high for the residents to see if they are in a wheelchair). Overall the residents were not aware of the required postings and where the postings are located. And the observation found no posting for the adult protective services, resident advocacy groups, home and community-based services, and the Medicaid Fraud Control Unit.	4 120	observations over the next three (3) months to ensure proper cleaning of pill cutters. -Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. -Observation reports and audits will be reviewed by the Quality Assurance Performance Improvement committee monthly for 3 months or until such time consistent substantial compliance has been achieved as determined by the committee. DON and/or designee. Corrective action completion date: 3/24/20.	
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		3/24/20

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4 136	Continued From page 5 This Statute is not met as evidenced by: Based on observation, record review and interview with staff members, the facility failed to ensure residents received treatment and care needed in accordance with their comprehensive person-centered care plan to meet the resident's highest practicable physical well-being. Resident (R)40 has been non-compliant with taking medications and completing dialysis treatments, there is no evidence that based on a root cause analysis (assessment) for R40's refusals, the care plan was revised to develop interventions to address R40's noncompliance with medications and hemodialysis treatment. Findings include: Cross Reference F550. On 02/04/20 at 09:30 AM during initial screening of the residents, Resident (R)40 was observed sitting up at bedside. The bedside tray was placed in front of the resident, there were two small disposable plastic containers, each containing tan/brown colored substance in it with a spoon stuck into the substance. The resident was asked what that was, R40 responded he/she doesn't know what that is as he/she just got up. Later Certified Nurse Aide (CNA)2 entered the resident's room, the CNA was asked what was in the cups, the CNA responded it looked like pudding and applesauce. The CNA reportedly was going to provide morning care and dress R40. Registered Nurse (RN)1 was observed entering the room with the CNA. The door was closed. At 10:15 AM, the door was opened and found the CNA taking out the laundry. RN1 was pushing R40 in the wheelchair. Inquired what was in the two containers, RN1 replied it was	4 136	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Upon notification of the deficient practice resident # 40's care-plan was reviewed and revised to reflect non-compliance with medication and hemodialysis treatment. RN #1 was provided education about leaving pudding and/or applesauce at the bedside. 2. Identification: Residents who are non-compliant with medication and / or treatment will be audited to ensure that proper medication and treatments are being provided additionally care plans will be audited to reflect residents non-compliance with medication and hemodialysis as appropriate. Appropriate follow up initiated based on audit results. 3. System Change: An in-service education program was conducted with the Interdisciplinary Team addressing the importance of accurately developing a comprehensive	

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4 136	Continued From page 6 applesauce and pudding which was placed on the resident's bedside tray as the resident was refusing to take medication. The RN stated the applesauce and pudding were prepared should the resident agree to take his/her medications. While strolling the resident out of the room, RN1 stated R40 has been refusing to take his/her medications and has been "temperamental" so the facility will schedule a meeting. A record review was done on the afternoon of 02/06/20 and morning of 02/07/20. R40 was originally admitted to the facility on 10/10/19 and was discharged to an acute hospital. R40 was discharged from the acute hospital and readmitted to the facility on 12/13/19. R40's diagnosis includes: chronic kidney disease, Stage 5; chronic obstructive pulmonary disease; atherosclerotic heart disease of native coronary artery without angina pectoris; dependence on renal dialysis; and insomnia. A review of the physician's orders and Medication Administration Record (MAR) was done. The review found orders for the following medications are scheduled for administration at 06:00 AM: omeprazole capsule delayed release, 20 mg; sevelamer carbonate, 800 mg; aspirin EC, 81 mg; nephron-vite tablet, 0.8 mg; amlodipine, 10 mg; hydralazine HCl 100 mg; clopidogrel bisulfate, 75 mg; lisinopril, 20 mg; metoprolol succinate extended release, 100 mg; cholecalciferol 2000 unit; bisacodyl tablet delayed release, 5 mg and escitalopram oxalate, 10 mg. R40 has 12 medications scheduled for administration at 06:00 AM. In addition, there is an order for clonidine HCl tablet 0.1 mg two times a day for hypertension, scheduled for 0800 and 1600. A review of the MAR for the month of January	4 136	person-centered care-plan to reflect the resident's current status. An in-service will also be completed with licensed staff to ensure pudding/apple sauce is not left at the bedside. Monitoring: -The facility will conduct a random audit weekly for residents on hemodialysis and/or receiving medications for four (4) consecutive weeks and quarterly thereafter to ensure a root cause analysis for their non-compliance has been completed prior to their care-plan revision. Additionally, routine audits will be completed on residents receiving medications at the bedside weekly four weeks to ensure compliance -Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. -This plan of correction will be monitored at the monthly Quality Assurance Performance Improvement meeting until such time consistent substantial compliance has been met. Director of Nursing and/or designee Corrective action completion date: 3/24/20.	

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4 136	Continued From page 7 2020 found documentation of R40's refusal of medications. R40 refused medications on the following days: 01/01/20 (refusal of one medication); 01/02/20 (refusal of 8 medications); 01/03/20 (refusal of one medication); 01/04/20 (refusal of 2 medications); 01/07/20 (refusal of 11 medications); 01/08/20 and 01/09/20 (refusal of 3 medications); 01/12/20 (refusal of one medication); 01/14/20 (refusal of four medications); 01/16/20 (refusal of two medications); 01/17/20 (refusal of one medication); 01/18/20 (refusal of two medications); 01/20/20 (refusal of 8 medications); 01/22/20 (refusal of 7 medications); 01/23/20 (refusal of one medication); 01/25/20 (refusal of seven medications); 01/27/20 (refusal of 11 medications); 01/28/20 (refusal of two medications); 01/29/20 (refusal of 8 medications); 01/30/20 (refusal of 9 medications); and 01/31/20 (refusal of 3 medications). R40 refused medications on 18 of the 31 days in January. A progress note dated 01/31/20 documents resident's refusal of 08:00 PM medications stating, "they are too big and too much". The resident was also noted as saying "Please, don't call me sister." The review for February 2020 found R40 refused all morning medications on 02/01/20, 02/03/20, 02/04/20 and 02/05/20. The progress notes from 12/19/19 through 02/07/20 were reviewed. On 12/29/20, R40 was sent to emergency from the dialysis entity due to complaints of chest pain and anxiety. R40 returned to the facility. On 01/24/20, R40 went on an overnight pass for a family funeral. On 01/27/20, R40 refused to go to dialysis. There is documentation of R40 not completing dialysis treatment on 01/29/20, 01/31/10, 02/03/20, and 02/05/20. The physician met with the resident on 02/05/20 to discuss the resident's noncompliance	4 136		

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4 136	Continued From page 8 with medication and hemodialysis treatments (build-up of toxins which could lead to sepsis). R40 refused treatment on 02/07/20. At this time social services and the nurse met with the resident to educate R40 on the risks and benefits of the noncompliance. On 02/06/20 at 11:23 AM an interview was conducted with the Director of Nursing (DON). The DON reported she spoke to RN1 regarding leaving the pudding and applesauce at the resident's bedside would appear that the resident's medications were left at bedside. In regard to the resident's refusal of taking medications, the DON responded, when resident's refuse the nurses should wait and approach the resident at another time. The DON also shared that he/she was able to get R40 to take the medications by sitting and talking with the resident. Inquired whether approaches were developed to address the resident's refusals including interventions to take the time and visit with the resident during the medication administration. On the morning of 02/07/20, the MDS Coordinator (MDSC)1 reported a meeting with the family had been scheduled for 02/12/20 (Wednesday). Inquired whether the dialysis entity will participate in the meeting, the MDSC1 responded, they will be invited.	4 136		
4 199	11-94.1-46(p) Pharmaceutical services (p) When appropriateness of drugs or dosage of drugs as ordered are questioned by the pharmacist or licensed nurse, the licensed nurse or the pharmacist shall consult the physician, and a record of the consultation shall	4 199		3/24/20

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4 199	Continued From page 9 be made available to the administrator of the facility or director of nursing. This Statute is not met as evidenced by: Based on record review and interview with staff member, the facility failed to accurately monitor, assess, and document behaviors for use of psychotropic medications; and, ensure as needed (PRN) orders for psychotropic medication are only used when the medications are necessary and the PRN use of a psychotropic medication is limited to 14 days (unless a rationale for continued use is provided) for 3 of 7 residents sampled for unnecessary medications. In addition, the facility failed to implement Resident 124's care plan to document behavior episodes to identify triggers. Findings include: 1) On 02/06/20 at 09:04 AM, RR showed R27 was initially admitted to the facility on 11/24/17 and readmitted on 04/17/19. Diagnoses: chronic obstructive pulmonary disease, cellulitis of right Toe, hypertension, cognitive communication deficit, dementia without behavioral disturbance, contracture right/left ankles, dysphagia, gastrointestinal hemorrhage, alcohol use, quadriplegia, major depressive disorder. R27 was on the following medications: Prednisone, Levothyroxine, Lactulose, Diltiazem, Zofran, Seroquel, Buspirone, Morphine, Senna, Bupropion, Melatonin, Acetaminophen, Ipratropium-Albuterol, Dulcolax, Bisacodyl, Fleet enema. On 02/04/20 at 09:40 AM, interview attempt with R27 revealed resident was in a foul mood. R27 was observed to be irritable and yelled at	4 199	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 27, 124 and 125 have behavior monitoring tools and documentation that reflect their current status. 2. Identification: Residents' receiving psychotropic medication will be audited to ensure compliance with requirements of 785. Issues noted during the audit will be corrected upon identification. 3. System Change: Nursing staff have been in-serviced on the importance of monitoring and documenting behaviors for residents receiving psychotropic medications. Additionally, licensed staff have been in	

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4 199	Continued From page 10 surveyor, stating "I am not in a good mood, what do you want?" After surveyor stated his name and where he was from, R27 told surveyor to "Get Out!" Subsequent attempts to interview R27 resulted in similar outcomes. On 02/07/20 at 10:05 AM, RR of R27's "Behavioral Monitoring Sheets" for the month of January and up to February 6, 2020, staff documented "0" behaviors daily. R27 was on Seroquel 25 milligram (mg) by mouth twice a day for depression, Buspirone XL 5mg by mouth twice a day for anxiety, Bupropion XL 300mg by mouth daily for depression. R27's physician ordered "Behavioral Monitoring" for psychotropic medication use. RR of R27's care plan under interventions reflected the following: "Monitor for behaviors as evidenced by calling out, swearing, hallucinations. Document number of times behavior occurs." On 02/07/20 at 09:09 AM, interviewed the Director of Nursing (DON) and Minimum Data Set Coordinator (MDSC) 1, both concurred there is a lack of accurate documentation by the facility staff regarding behavior monitoring of residents who are on psychotropic medications including R27. DON stated facility staff see residents' behaviors daily, and think no change from previous day, not realizing that the behavior is not the norm and needs to be accurately documented. Both DON and MDSC1 stated facility staff need more education and training on how to document specific or target behaviors for residents who are on psychotropic medications. 2) Resident (R)124 was admitted to the facility on 01/14/20. Admission diagnoses include:	4 199	serviced on the PRN antipsychotic 14-day regulatory requirements. 4. Monitoring: -The facility will conduct a random audit of sample residents weekly for residents on residents receiving psychotropic medications for four (4) consecutive weeks and quarterly thereafter to ensure behaviors are accurately documented and PRN antipsychotic 14-day regulatory requirements adhered to. -Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. -This plan of correction will be monitored at the monthly Quality Assurance Performance Improvement meeting until such time consistent substantial compliance has been met. Director of Nursing and/or designee Corrective action completion date: 3/24/20.	

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4 199	Continued From page 11 anxiety disorder, unspecified; essential hypertension; nontraumatic intracranial hemorrhage, unspecified; muscle weakness; and difficulty in walking. On 02/06/20 at 08:38 AM a record review found a physician's order for alprazolam 0.25 mg, one tablet by mouth every 12 hours as needed for anxiety. The start date was 01/14/20, the end date was documented as "indefinite". A review of the Medication Administration Review (MAR) documents administration of alprazolam on 02/03/20 at 07:43 AM. There were no indicators of anxiety documented in the behavior monitoring log for anxiety. A review of the resident's progress notes found no documentation R124 was exhibiting anxiety or the need for administration of the alprazolam. A review of R124's care plan found the following goal, "I at times request for my anti-anxiety medication for episodes of anxiety. I am at risk for side effects to medication." The interventions include the following: non-pharmacological interventions - 1:1 interaction, re-direct, nature strolls, soft music or comfort food; monitor and record my anxiety episodes and document per facility protocol; monitor for behavior episodes to identify triggers (consider location, time of day, persons involved and situation); monitor for side effects; psych medication review per facility protocol/process; review medication; and evaluate the use of anti-anxiety medication for gradual dose reduction. On 02/06/20 at 11:10 AM an interview and concurrent record review was done with the Director of Nursing (DON). The DON stated PRN orders for psychotropic medication should not exceed 14 days. The DON confirmed the order	4 199		

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4 199	Continued From page 12	4 199		

for alprazolam exceeded 14 days and would further review the record whether the physician documented a clinical rationale for continuation of the PRN order. Concurrent record review with the DON found no documentation of a progress note or documentation in the MAR to indicate the need for administering the anti-anxiety medication. Also, inquired whether there are parameters to determine when the anti-anxiety med was needed (i.e. administering anti-anxiety med after non-pharmacological interventions are tried). The DON was agreeable to further review R124's medical record for the following: rationale for prescribing anti-anxiety medication for more than 14 days and documentation of the anxiety episode which warranted the PRN anti-anxiety med (administered 02/03/20).

On 02/06/20 at 03:55 PM, the DON confirmed there was no documentation for R124 of a clinical rationale by the physician for prescribing the anti-anxiety med PRN order indefinitely (greater than 14 days), and no documentation of the anxiety episode prior to the administration of the anti-anxiety medication.

2) R125 was admitted to the facility on 01/28/20 with the following admission diagnoses: metabolic encephalopathy; difficulty in walking, not elsewhere classified; hyperlipidemia, unspecified essential (primary) hypertension; type 2 diabetes without complications; unspecified dementia without behavioral disturbance; anxiety disorder, unspecified; and panic disorder (episodic paroxysmal anxiety) without agoraphobia.

On 02/05/20 at 09:44 AM a record review was done. A review of the physician's order found the following prescribed psychotropic medications:

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4 199	Continued From page 13 mirtazapine 15 mg, give one tablet by mouth at bedtime for depression; escitalopram oxalate 20 mg, give one tablet by mouth one time a day for major depressive disorder; propranolol HCl 40 mg, give one tablet by mouth two times a day for anxiety/hypertension; and lorazepam 0.5 mg, one tablet by mouth every eight hours PRN for anxiety/agitation. The PRN prescription for lorazepam had a start date of 01/31/10 with an indefinite order. A review of the MAR found PRN administration of lorazepam on the following days: 02/02/20 at 06:00 PM; 02/03/20 at 09:35 AM; 02/04/20 at 03:30 PM; 02/05/20 at 01:35 PM; and 02/06/20 at 08:10 AM. On 02/06/20 at 11:15 AM an interview was conducted with the DON. The DON confirmed the PRN order for lorazepam had an end date of "indefinite". The DON acknowledged the regulation for psychotropic PRN orders of 14 days and stated the PRN order should have had an end date of 02/14/20. The DON found a pharmacy recommendation to the physician to review the PRN order. The notification from the pharmacist was dated 02/02/20; however, the physician did not provide a response.	4 199		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by:	4 203		3/24/20

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4 203	Continued From page 14 Based on observations, staff interviews and policy and procedures (P&P) review, the facility's infection prevention and control program (IPCP) failed to maintain standard precautions for safe handling of equipment or items that are likely contaminated with infectious body fluids, as well as cleaning and disinfecting or sterilizing of potentially contaminated equipment. As a result of this deficiency, residents are at an increased risk of development and transmission of communicable diseases and infections. Findings Include: 1) On 02/06/20 at 11:45 AM observed RN2 perform a blood glucose test on R176 using a multi-use glucometer. After reading the results, RN2 wiped the glucometer with a paper towel that had hand sanitizer gel on it. RN2 walked back to the unit's med cart and placed the glucometer on the top of the cart. RN2 then went into the unit's activity/dining room to help pass out lunch trays, came out of activity/dining room, went down the hall with a tray, came back to the med cart, grabbed the glucometer from the top of the med cart, and placed it into the top drawer of the cart. Inquired of RN2 on the facility's P&P for sanitizing the glucometer after use. RN2 stated that sani-cloth from the red top container was used to wipe the glucometer before and after use. There was no red top sani-cloth container in the vicinity of the med cart, and inquired where the red top container was located. RN2 stated that the red top container was kept in the medication supply room adjacent to the unit's nursing station, and that the glucometer was taken into the med room and sanitized. Shared above observations with RN2, and that did not observe her taking the glucometer into the med room. RN2 insisted that	4 203	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Upon notification of the deficient practice the nurses identified (RN #2 and 10) have been in-serviced on the proper procedures for glucometer disinfection. CNA's #2 and 8 were provided training for sanitizing protective equipment in the dirty laundry room. R#17 and 37 have their urinals appropriately stored. 2. Identification: An audit will be conducted regarding proper glucometer disinfection, blood pressure cuffs, and sanitation of protective equipment. Additionally, the facility will audit infection control ensure sanitation of protective equipment in the dirty laundry room & appropriate storage of urinals. Appropriate follow up will be initiated based on audit results. 3. System Change: The licensed nursing staff will be	

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4 203	Continued From page 15 the glucometer was sanitized and that may have missed observation because she moves around quickly. Explained to RN2 that followed her from R176's rm to the med cart, sat right by med cart to specifically observe how glucometer was to be sanitized, and did not observe RN2 take glucometer from med cart into the med room. On 02/07/20 at 10:00 AM provided above observations during meeting with the director of nursing (DON) and administrator (ADM). The DON stated that red topped sani-cloth containers are kept in each med cart drawer to sanitize the glucometer, and that nurses shouldn't have to go into the med room to sanitize the glucometer. 2) On 02/06/20 at 08:14 AM, observed RN10 taking Resident (R)35 blood pressure with a manual blood pressure cuff in preparation to administer Lorasartan 100 mg. After obtaining R35's blood pressure, staff then placed the blood pressure cuff on the resident's bed. RN10 took the manual blood pressure cuff that was draped over the right side of the medication cart, took it into R35's room, used the manual blood pressure cuff on R35, placed the blood pressure cuff on the bed, administered meds, exited the room, placed the blood pressure cuff back on to the medication cart, and proceeded to provide care for another resident. RN10 did not disinfect the blood pressure cuff before taking the blood pressure cuff into the room, while in the room, or before placing the cuff back onto the medication cart. The area of the medication cart where the unsanitizied blood pressure cuff was placed was not disinfected also. RN10 confirmed the blood pressure cuff should be sanitized with the "red wipes" (Medline Micro-Kill+ wipes). There were no container of Medline Micro-Kill+ wipes on or in the medication cart utilized by RN10.	4 203	in-serviced on the facility's Glucometer Disinfection policy and Practice Guideline. In-service training included observation of nurses performing return demonstration on the procedure. Corrective action was provided as needed. Nursing staff will be in-serviced on disinfecting blood pressure cuffs, on the proper procedure for storing urinals and how to sanitize and clean protective equipment in the dirty utility room. A cleaning schedules were reviewed and updated to include cleanings of boots and soiled aprons. 4. Monitoring: -The facility will complete random Validation Checklists of nurses performing glucometer disinfection to ensure nurses are performing the procedure in accordance with our facility's Practice Guideline. Routine audits and observations will be completed; audits will be completed in residents' rooms and the dirty laundry area to ensure infection control practices identified on F880 are adhered to weekly x 4 weeks then monthly thereafter until substantial compliance is met. -Corrective action is to be taken immediately and staff education is to be provided as deemed necessary. -Validation Checklists and audits will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has	

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4 203	Continued From page 16 Further inspection of the entire facility on 02/06/20 at 09:30 AM, observed only two containers of Medline Micro-Kill+ wipes readily available for staff use located on: 1 of 4 medication carts in the facility on the Ka Maka unit; near the sink of one nursing station used by the Kamakau Wing and the Lehua Kona Wing. On 02/07/20 at 08:45 AM, during review of the facility's Infection Control Program, the infection preventionist (IP), stated the blood pressure cuff should have been disinfected prior to leaving the residents room with the "red wipes". 3) Multiple observation throughout the entire survey (02/04/20 at 09:42 AM through 02/07/20 at 09:40 AM), observed two resident's [(R)17 and R37)] urinals were placed in the resident's trash bin for storage. The urinals were placed in a manner in which the handheld portion to the urinal rested on the lip and on the inner portion of the trash bin. The trash bins were stored on the ground near each resident's bed. R17's and R37's trash bin contained various trash including but not limited to: used gloves; tissues used to wipe the resident's mouth and blow his nose, paper towels; and food wrappers. On 02/07/20 at 09:00 AM, inquired of the facility's IP on where urinals should be kept. The IP stated the resident's urinals should be stored on the side of the resident's bed frame and not in the resident's trash bin. A document provided by the facility, "Legacy Hilo Rehabilitation & Nursing Center Survey Reminder..." (revised 07/10/19) documented "Infection Control Issues....Place bed pans & toilet hats in the resident's night stand (bottom drawer)." The IP staff also stated the facility conducted Infection Control rounds which	4 203	been achieved as determined by the committee. DON and/or designee. Corrective action completion date: 3/24/20.	

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4 203	Continued From page 17 monitored the labeling and appropriate storage of urinals, but could not produce documentation of completed Infection Control Rounds sheet upon request. At approximately 10:50 AM, RN15 provided a different facility document "Infection Control Focus Rounds Resident Rooms" which was conducted on 02/06/20 at 02:30 PM, however, this document did not include monitoring of the appropriate storage of resident urinals. 4) On 02/07/20, requested appropriate policies and procedure, to which RN15 provided "Care and maintenance of protective clothing" document, which states protective clothing should be inspected for cleanliness and working order; used during spraying operations; thoroughly washed, rinsed, dried in an airy environment; washed at the end of each day's spraying operation (if spraying is done on two or more days in a row); removed and placed for laundering; and changed if heavily soiled. On 02/07/20 at 09:45 AM, upon inspection of the "dirty" laundry room located on the Lehua Kona and Na Maka wings, observed a yellow, heavy-duty reusable apron, with a shoelace used to secure the apron around the user's neck and a pair of black rubber gloves hanging in the "dirty" laundry room, were visibly soiled. Certified nurse assistant (CNA)8 stated the apron and gloves were used by staff when rinsing soiled linen from residents rooms. Upon inspection of the equipment, CNA8 acknowledged the presence of unknown residue on both sides of the apron. Further inquiry with various staff (2 CNAs, 2 housekeepers, and the Housekeeping Manager) from the Na Maka and Lehua Kona wings confirmed staff does not sanitize/clean the equipment, is unaware of the procedure to	4 203		

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4 203	Continued From page 18 sanitize/clean the equipment. The Housekeeping Manager confirmed the apron and gloves in questions has not been sent through the laundry services to be sanitized/cleaned. Various staff further acknowledged and confirmed the exterior of rubber boots (used when showering residents) are not sanitized/cleaned after use, including incidents in which the boots are in contact with fecal matter.	4 203		