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	125051	A. BUILDING: _____ B. WING _____	03/02/2020

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4 000	Initial Comments A state re-licensure survey was conducted at the facility from 02/25/20 - 03/02/02. The facility's census was 91 residents at the time of entrance.	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, interview and record review, the facility failed to ensure each resident was treated with dignity and respect, and that staff's interaction with residents took into account the physical limitations of the resident and failure to appropriately communicate or provide services for them. The failure to provide the residents with respect and dignity occurred for two of 19 residents (Residents (R) 132 and 179) selected for review. This deficient practice had the potential to affect all residents residing in the facility. Findings Include: 1) R132 was admitted on 02/07/20 for short term	4 115	Corrective Action R132 was discharged from the facility on 3/5/2020. CNA53 received 1:1 education regarding resident rights, dignity and respect on 4/22/2020. R179 continues to be intact. Care plan reviewed and updated on 4/27/2020 to reflect resident's preference. Identification of Others All residents who require assistance are considered to be affected by this practice. Executive Director initiated education on 3/3/2020 regarding treating residents with dignity and respect, self-determination and a dignified existence. A 100% audit was	4/16/20

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4 115	Continued From page 1 rehabilitation (STR) services. During an interview with R132 on 02/26/20 at 10:28 AM, R132 could express her thoughts and sentences slowly, and described a particular event involving a night shift staff who recently cared for her. During her interview, R132 stated a certified nurse aide (CNA) on the night shift who, "worked two nights ago" told her, "hurry up, hurry up" in order to toilet her. R132, who wore a neck brace due to diagnoses of a displaced fracture of her second cervical vertebra (spine), generalized muscle weakness and difficulty walking, said the CNA's actions and verbalizations made her feel, "less than a human being." R132 stated, "She did not treat me with respect and dignity." During the facility's separate, concurrent abuse investigation of this event, a certified nurse aide (CNA53) was identified from the staffing schedule and interviewed on 02/27/20 at 04:42 PM by the surveyor. CNA53 verified she knew who R132 was and was assigned to her during the 02/25/29 night shift from 10:00 PM to 6:00 AM. CNA53 stated R132, "is a non-compliant resident" who would stand often and, "moving to go to the bathroom." CNA53 said she told R132, "If you fall down, your husband will be mad and I will be liable for you because I'm on duty that's why." CNA53 said she told R132 this only once to make the resident aware. CNA53 said she knew it was not respectful to say this to R132. CNA53 acknowledged she became frustrated with R132 and said, "Maybe because that night she keeps standing and I saw already she go open bathroom alone and I saw her finish going to the bathroom already. And before going home, I saw her again in the hallway."	4 115	completed on 4/27/2020 on interviewing residents if they feel staff are treating them with dignity and respect; and another 100% audit was completed on reviewing continence status and preference wearing a brief or not. Systemic Change The resident has a right to a dignified existence, self-determination, and communication. Staff Development Coordinator initiated all staff education on 4/26/2020 regarding resident rights, respect, and dignity. DON educated nurse managers on 4/27/2020 to include continence status and preferences on wearing a brief into the care plan. Upon admission and as needed, nursing will review continence status/preferences with residents, and update the care plan. Monitoring Change The Executive Director or designee will interview five random residents per week x 4 weeks to ensure staff treat residents with dignity and respect; and the Executive Director or designee will interview five random residents per week to determine if new residents were interviewed about their continence status and preferences to wear a brief. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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4 115	Continued From page 2 CNA53 also said on that night shift, she had a total of three restless residents which added to her frustration. CNA53 however, recognized and stated it was not respectful telling R132 that she would be a liability to her, especially since R132 required frequent supervision based on CNA53's interview. 2) Resident (R)179 was admitted to the facility on 02/19/20. During an interview on 02/25/20 at 10:17 AM, R179 stated to this surveyor that he/she is wearing a diaper. They put it on him/her. Surveyor asked, "Is it ok with you?" R179 replied "No." Observation on 02/27/20 at 0700 AM where R179 was brought to the activity/TV area. Surveyor observed R179 in activity room from 0700 AM until 10:59 AM. AT 11:00 AM, he/she went to the main dining area for ice cream gathering. R179 returned to the activity area after the ice cream gathering from the main dining area around 12:40 PM. R179 remained in the activity/TV area until 0200 PM. Interview at 02:02 PM - queried with R179 if his/her "diaper" had been changed. R179 said "no." Interviews: Query with registered nurse (RN)10 and certified nurse's assistant (CNA)5 if R179's diaper could be checked. Accompanied staff to room with diaper change. At the bedside, it was noted that R179's diaper was saturated with urine. Upon questioning of staff, CNA5 stated that R179 had not been changed since the am. R179 re-iterated to RN10 and CNA5 that he/she does not like using a diaper. RN10 and CNA5 agreed that sitting in a wet diaper for six hours could lead to urinary tract infection (UTI) and	4 115		

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4 115	Continued From page 3 pressure sores. RN10 stated that they could trial using a urinal for urination. The resident suffered for six hours with a saturated diaper for six hours. This deficient practice placed the resident at a potential risk of urinary tract infection and skin breakdown. This practice denies R179 of his right to self-determination and a dignified existence.	4 115		
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, staff interview and record review, the facility failed to provide sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial wellbeing. Findings Include: 1) An abbreviated Resident Council (RC) meeting was held during the survey on 02/26/2020 at 11:00 PM. There were five residents (R) in attendance to RC. They were resident (R) 61, 35, 281, 36 and R8. The question was asked to the residents if they	4 148	Corrective Action R61 R35 R281 R36 and R8 were interviewed on 4/29/2020 on call light response time and if residents needs are being met. Refer to plan of correction for the following deficiencies: F550, F622, F623, F656, F657, F685, F688, F689, F690, F726, F745. Identification of Others All residents have the potential to be affected by this practice. A 100% audit was completed on 4/30/2020 to determine if call light is answered in a timely manner and staff is meeting their needs.	4/16/20

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4 148	Continued From page 4 get the help that is needed without waiting a long time and if the staff response to the call light is timely? One of the residents responded that "in the morning and in the afternoon, the nurses are doing showers, they cannot see the lights, so you may have to wait....30 minutes." Another resident chimed in and stated, "that sounds about right." Resident agreed and said the staff busy are busy and we wait 20 to 30 minutes. Resident went on to say "the cna will let the nurse know if we call and they don't answer call lights. It's mostly the shower times, in the morning or in the afternoon. They are short staff most of the time, it doesn't matter what shift. I look at them and they are tired. Every morning, I ask them "how many are on and they say two and they look so tired." R35 stated "they are able to turn off the call lights without coming to the room, especially at night and I push the button at night and in five minutes, they turn the light off. On our side, they must physically come into the room and turn it on. R36 stated, "I don't blame them if they are irritated with me because I have to go to the bathroom, and I think they are overworked." Observation was made on the night shift at 0400 AM during the survey dates 02/25/2020 through 03/02/2020. For the purpose of anonymity, dates and identifiers will not be identified to respect the request of staff who wish to remain anonymous. Entrance to the first unit showed four call lights on. Census was 51. Two registered nurses (RN) and two certified nursing assistants (CNA) were on the floor in rooms. Surveyor timed call light at 9-10 minutes of initial visualization. Entrance to 2nd unit showed three resident lights were on. Standing in hallway, where all halls could be visualized, there was no staff available. Interview with anonymous staff who stated that	4 148	Systemic Changes The facility implemented creative staffing schedules/patterns for nursing staff on 2/17/2020 to address a staffing shortage which includes 4, 8, and 12 hour shifts. By implementation of this new pattern facility went from 17 open shifts down to 4 open shifts. As a result, beginning 3/5/2020 the RNA's were no longer being pulled to the floor as CNAs. The Executive Director, DON, and Staffing Coordinator will weekly and as needed to review and assess staffing patterns and making adjustments as necessary to ensure sufficient staffing based on acuity. The facility offers a sign on bonus and have partnered with Healthcare School of Hawaii (CNA training school), upon completion of clinicals the facility will pay for Prometric testing as a recruitment plan. The Executive Director, DON/ADON, Staffing Coordinator, and HR will meet weekly to discuss staffing needs and formulate a plan. Monitoring Changes The Executive Director/designee will conduct ten random weekly audit to determine that the facility is meeting the residents' needs and call light response time acceptable. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 90 days to ensure compliance is achieved and maintained.	

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4 148	Continued From page 5 "we budget our time, we have no assignment, it's hard, we just go." Upon return to first unit, interview with anonymous staff who started to cry and said "it's overwhelming. Surveyor asked, "how do you manage when four lights go off?" Staff stated "we can't manage. I give good care and the residents feel rushed. I'm sorry. We get in trouble." Staff excused her/himself to the restroom. 2) The facility failed to determine whether their staffing sufficiently met the needs of the residents. Cross-reference to F689. During a telephone interview of CNA53 on 02/27/20 at 04:42 PM, CNA53 said for their night shift schedule, they had two CNAs on the Keolamau unit. CNA53 said at times, two CNAs were enough; however, having restless residents, "we really cannot accommodate everybody." She said, "I know, always the safety of all." CNA53 said there were three restless residents on that particular night shift (cross-reference to F550), ". . . they are scattered, not one on side, in 600 and 500. And the half of the 500. So I had to go back and forth." CNA53 said one of the restless residents, R132, whom she described as "non-compliant," would stand up and walk around unassisted inside and outside of her room. CNA53 said it was really hard with only two CNAs staffed at night on their unit. She acknowledged she may have been getting frustrated with R132 as the resident kept standing, going to the bathroom unattended, and/or was found standing in the hallway unassisted. As a result, CNA53 said she told R132 that she would be blamed if the resident fell on that shift.	4 148		

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4 148	Continued From page 6 Observation of the night shift of the Keolamau unit was done on 02/28/20. At 06:16 AM CNA46 was interviewed and said she worked night shift on this unit a lot. She said sometimes they were short of staff and with only two CNAs at night, that sometimes it was difficult to provide safe care. She also felt at times they were rushing to provide care for their residents and said, "If you are doing the others, and a because especially you cannot go out cannot leave them if they are in the bathroom, . . . " and said the night shift could use more help. When she was asked how she was able to complete her work when they were short of staff and with restless residents, she said, "We are trying our best." CNA46 said she cared for 10 or 11 residents, but would also help assist the other CNA. She said it got very busy around 4:00-6:00 AM. She would prioritize by, "The one that need to go to the bathroom, because they are in a hurry and they cannot hold sometimes. You know already the client that need to be prioritized, I know. You must go at once because they might fall yeah," and identified three residents who were high risk for falls. CNA46 said, "Sometimes you are scared yeah about yourself, you must take care of them the best yeah, so that you cannot hurt them or hurt yourself also." On 02/28/20 at 02:26 PM, an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) was done. During the interview, it was found that although they addressed a staffing shortage which occurred during the month of January 2020 due to several employees leaving the facility, there still were no interim measures to assure that for some residents, they received their physician ordered services, (i.e., RNA care), or other needed care.	4 148		

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4 148	Continued From page 7 There also was no documentation to show whether residents were being adequately monitored on each given shift with the CNA shortage they described.	4 148		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on observations, interviews and record reviews (RR), the facility failed to adequately care plan the use of transfer equipment for one of 32 residents (R68) sampled for survey. The facility did not establish, document and implement the	4 149	Finding 1 Corrective Action R68 was discharged from the facility on 03/09/2020. CNA 51 was provided 1:1 training on use of slide boards with	4/16/20

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4 149	Continued From page 8 proper use of a slide board and gait belt to maintain R68's highest practicable quality of care and services. Findings Include: On 02/25/20 at 10:12 AM interviewed R68 as part of initial pool sample. Questioning about any recent falls in facility and R68 responded that he/she was dropped to the floor by CNA51 approximately two weeks ago. According to R68, a slide board is used to transfer from the bed to a wheelchair, and CNA51 never transferred her using the slide board. R68 told CNA 51 that transfer with slide board should be with 2 people but CNA51 insisted that she could do it. During the transfer procedure CNA51 couldn't hold on to R68 and had to drop him/her to the floor. R68 stated that had increased pain to left (L) groin area that was relieved with acetaminophen. The minimum data set (MDS) with assessment reference date (ARD) 02/05/20, for R68's functional status, included extensive assistance for bed mobility and transfers that required two people to assist. The MDS balance during transition codes noted that R68 was not steady, and only able to stabilize with human assistance for surface-to-surface transfers (e.g. bed to wheelchair). The MDS also coded R68 with limitation in range of motion (ROM) to both sides of the lower extremities, and used a wheelchair for mobility. The MDS coded R68 on a scheduled pain regimen in the last five days and was on opoids on admission. For the MDS assessment R68 was a participant and the activity of daily living (ADL) and rehabilitation potential care area was triggered for this ARD as well. On 02/27/20 at 11:31 AM reviewed R68's	4 149	transfers on 2/20/2020. Identification of Others A 100% audit was conducted by DON on 4/23/2020 of all residents who require the use of transfer devices to ensure that their care plans correctly identified transfer equipment if indicated. Systemic Changes Resident care plans will include intervention of any transfer equipment as indicated. New admissions will be reviewed by Nursing Leadership and care plan will be initiated to include transfer equipment. Any changes in transfer status/equipment communicated by the therapy team will be communicated to Nursing and MDS and updates will be made to the resident's care plan and Kardex. Any changes in transfer status noted by nursing will be communicated with the therapy team for possible evaluation, if warranted. a. Education will be conducted by the Director of Nursing or designee by 04/27/2020 with the Nurse Management team on the process of ensuring that transfer status is correctly reflected in the care plan and Kardex. b. Education will be conducted by Director of Rehab by 04/29/2020 with the Therapy team on communicating any changes/recommendations to Nursing and MDSC for updates/changes that need to be made to the care plan and Kardex. All new hires will be trained during orientation on slide board transfers and annually thereafter.	

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4 149	Continued From page 9 electronic medical record (eMR) and noted care plan (CP) for ADL self-care deficit as evidenced by needs assistance with daily care related to disease process/condition: spinal stenosis, . . ., s/p T9-10 decompression on 01/21/2020; weakness; and presents with impairments in balance, dexterity, gross motor coordination, mobility, strength (ADLs/Mobility). The interventions included: requires extensive assistance by (1) staff to turn and reposition in bed and as necessary; and, requires extensive assistance by (1) staff to move between surfaces and as necessary. The CP for at risk for fall related to injury as evidenced by history of fall, with fall score >10 unable to perform test for balance without physical support; use of assistive devices (wheelchair and front wheel walker); other decline in ability to perform functional activities without physical assistance, dynamic balance, functional ambulation, and functional mobility, static balance, and strength; noted history of fall on 2/17/20. Interventions included: gait belt on with all transfers created on 2/17/20 ; when rising from a lying position, sit on side of bed for a few minutes before transferring/standing. On 02/27/20 at 2:19 PM interviewed CNA45 and reviewed R68's kardex with her. R68's kardex noted under transfer that resident required extensive assistance by (1) staff to move between surfaces, and as necessary per rehab, to transfer using slide board. Under mobility it was noted that gait belt on with all transfers. The MDS with ARD of 02/05/20 was not reflected in R68's CP for extensive 2 person assistance for transfers and bed mobility. Also, R68's CP did	4 149	Monitoring Changes The Executive Director or designee will review five random residents per week x 4 weeks to review care plans for appropriate goals and interventions. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained. Finding 2 Corrective Action R15 continues to reside in the facility care plan reviewed and updated on 4/23/2020. Medical Provider (NP) note dated 2/17/2020, discussed harmful repercussions of uncontrolled diabetes. Identification of Others All residents who refuse care have a potential to be affected by this practice. A 100% audit was conducted on 4/29/2020 of residents who refuse care. Care plans were reviewed and updated with appropriate interventions. Systemic Changes Nursing and social service staff were educated on 4/21/2020 that all resident who are refusing care or noncompliance with care have a care plan in place with appropriate interventions addressing the refusal of care. Education includes appropriate collaboration and interventions specific to resident. Monitoring Changes The Executive Director or designee will	

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4 149	Continued From page 10 not include the use of the slide board for transfers and the use of a gait belt until after the fall. The nursing CP was separate from the rehab CP and interventions to provide quality care and services to R68 was not measurable. 2) 1) Surveyor reviewed R15's medical record. Nurse Practitioner (NP)10 notes dated 02/17/20 state R15 is a 74-year-old female with weakness, history of stoke, Diabetes mellitus type two with renal manifestation, major depressive disorder, mood swings, congestive heart failure (CHF), hyperlipidemia, severe obesity with BMI >40 Hypothyroidism. R15 is non-compliant with medication regiment. Chronic kidney disease stage 5, labs done on 05/2019 Creatinine - 3.15, GFR - 14. No eye exam found in hard chart. MDS quarterly review dated 12/31, 2019. Vision coded as "adequate" and 1. corrective lenses. R15 care plan with review date 01/03/20, no interventions in the care plan to appropriately address the refusal of care and going against medical advice, and noncompliance behavior. The following interventions are written in the care plan: Administer medications as ordered. Allow extra time for R15 to respond to questions and instructions. Communicate with R15 family members about her capabilities and needs. Discuss concerns about confusion, disease process, R15 / family/ caregivers. Face and speak clearly when communicating with R15. Surveyor interviewed the physician (MD) on 02/28/20 at 10:31 AM to inquire if R15 had an eye exam for R15. MD stated that R15 often and frequently refuses care, adding that she refuses to go out for appointments and that the biggest concern is that she is stage 5 CKD and she also	4 149	review five random residents per week x 4 weeks to ensure that residents who refuse care have a care plan in place with appropriate interventions and physician was notified. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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4 149	Continued From page 11 refuses to have dialysis. Surveyor asked the MD why is R15 refusing her insulin. MD responded that she doesn't like to get poked. Surveyor reviewed the inter disciplinary team (IDT) meeting notes from the care plan conference record on 01/02/20. Resident continues to refuse blood sugar checks, labs pending, resident only wanting to get labs drawn at an outpatient clinic. Frequent refusal of care. Continue current plan of care. The facility is addressing the refusal behaviors in the IDT notes, it was noted in the progress notes that "certain" staff can give R15 her insulin. Reviewed the MAR and noted R15 only refused her insulin in the morning. The evening nurse was able to give the insulin. There was no documentation in the record that there was a discussion between the Resident and the physician (MD) about refusing the insulin and the harmful repercussions, i.e. chronic kidney disease (CKD) for doing so, or that the MD addressed the concerns and changed the treatment plan. There was no discussion documented in the IDT notes that certain staff were able to give the insulin and finally, there were no care plan interventions in place to address residents' behaviors with psychosocial interventions.	4 149		
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observation, interview and policy	4 197	Corrective Action	4/16/20

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4 197	Continued From page 12 review, the facility failed to discard medication from the medication cart and the medication refrigerator that was expired. The deficient practice had the potential to increase risk of illness for the residents residing in the Facility. Findings include: Surveyor conducted a random inspection of medication storage cart on Wailani unit in front of Room 301 on 02/27/20 at 09:23 AM and discovered a box with morphine sulfate oral solution, 100 mg per 5 milliliter (ml) with a "discard after date of 09/19" written on the opened bottle. Licensed Nurse (LN)12 verified that the bottle was expired and should be discarded and also was currently in use. LN12 added that we check and endorse to the other nurse at the end of the shift and the head nurse is responsible to check the cart and discard the expired medications. Surveyor interviewed the charge nurse (CN) on 02/27/20 at 09:45 AM who stated, it is the nurse's responsibility to clean out the med cart. At the end of the shift when they endorse to each other they should take the meds out that are expired. Surveyor conducted an inspection of the locked refrigerator in the medication storage room on the Wailani unit on 02/27/20 at 09:47 AM. An opened bottle of tubersol was discovered that did not contain a date opened on the bottle. The CN took the bottle out of the box and discarded it stating It is the responsibility of the nurses to throw out the discarded items and they should be writing an open date on the bottle. Surveyor reviewed the Long term care (LTC) Facility's pharmacy services and procedures	4 197	Expired and unlabeled medications were removed and discarded on 2/27/2020. A 100% audit was immediately completed for expired and unlabeled medications in the med carts on 2/27/20. Identification of Others All residents residing in the facility have the potential to be affected by this practice. A 100% audit was completed on 4/28/2020 of medication carts and medication rooms/refrigerator to ensure all expired medications were removed. Systemic Changes Nursing education initiated on 4/26/2020 on labeling and checking expiration dates for all medications in carts, medication room/refrigeration. Unit managers will conduct weekly medication room inspections to ensure medications are labeled and all expired medications are removed and discarded. Monitoring Changes The Executive Director or designee will conduct random weekly audits to ensure there are no expired medications in cart/room and all medications are labeled appropriately. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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4 197	Continued From page 13 manual 5.3 Storage and Expiration Dating of Medications, Biological's, Syringes and Needles. October 2016. Page 2, paragraph 5. "Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff may record the calculated...on date opened on the medication container. Medications with a manufacturer's expiration date expressed in month and year will expire on the last day of the month".	4 197		
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: Based on observation, interview and review of the facility's policy, the facility failed to provide a safe and sanitary environment which place residents, staff and visitors at risk of acquiring an infection. Hand hygiene infringements by staff, the failure to separate clean supplies from a dirty surface and the separation of a used item from a clean surface were observed. Findings Include: 1. The surveyor observed on 02/27/20 at 11:24 AM, in preparation for a dressing change, RN93 failed to place a clean barrier on the dressing cart	4 203	Corrective Action RN93 received 1:1 education on 2/27/2020 regarding dressing change, maintaining clean technique and maintaining sanitary environment at all times. Infection control course completed by RN93 on 4/30/2020. Staff education was initiated on 3/3/2020 to include hand hygiene. Identification of Others All residents have the potential to be affected by this practice. Week of 03/23/2020 audits were conducted and	4/16/20

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4 203	Continued From page 14 before laying out clean dressing supplies. The surveyor queried RN93 as to when the top of the dressing cart is disininfected and she stated that it is wiped only once in the morning. RN93 stated that she should have placed a clean barrier between the dressing supplies and the cart to prevent contamination. 2. On 02/27/20 at 11:46 AM, the surveyor observed RN93 exit a resident's room carrying an object in a pillow case. RN93 stated that it was an ice pack wrapped in a pillow case that a resident used for her leg pain. The surveyor further observed that she placed the used ice pack in a pillow case on her clipboard on the medication cart. She further stated that didn't know where the used ice packs were kept to be disinfected. 3. During observation of lunch on 02/25/20 at 12:25 PM, observed the cart arrival at 12:27 PM. The Clinical nursing assistant (CNA)s started room service at 12:28 PM. CNA1 grabbed a tray from the cart. On the way into the room, CNA1 pumped the hand sanitizer (HS) on the wall to her left hand while holding the tray and walked into the room. Surveyor did not see CNA rub HS into her palm. CNA came out of room 303 and placed the tray back into the cart without HS. CNA grabbed the next tray without proper HS. CNA delivered the tray to resident in room 302B without proper hand sanitization. In room 302b, CNA assisted the resident with opening lids of food containers and condiments. CNA1 came out of the room after assisting 302b. CNA2 arrived and CNA left without doing any HS. CNA2 passed the next two trays without HS going into the rooms. CNA2 HS after coming out of the rooms and almost forgot on one occasion, then turned back to HS. CNA2 did not hand sanitize going into the rooms.	4 203	ongoing of hand hygiene during meals. Systemic Changes Infection Control Monitoring Meal Service audits were initiated on 3/31/2020 and ongoing. Monitoring Changes The Executive Director or designee will conduct weekly observation to include dressing changes, infection control practices, and hand hygiene with meals. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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4 203	Continued From page 15 A review of the Policy and Procedure (P&P) dated 03/16/19 was reviewed on 02/25/20. The P&P states "handwashing/hand hygiene is generally considered the most important single procedure for preventing nosocomial infections. Antiseptics control or kill microorganiisms contaminating skin and other superficial tissues and are sometimes composed of the same chemicals that are used for disinfection of inaminate objects." The procedure is to utilize the Lippincott procedure for hand hygiene. This deficient practice placed the residents at risk for an unsafe, unsanitary and uncomfortable environment and does not prevent the development and transmission of communicable diseases and infections.	4 203		