Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125041	A. BUILDING: ______ B. WING ______	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILIHA HEALTHCARE CENTER	1814 LILIHA STREET HONOLULU, HI 96817

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4 000	Initial Comments A relicensure survey was conducted by the Office of Health Care Assurance (OHCA). The facility was not in compliance with Title 11 Chapter 94.1. Survey Dates: 02/07/22 to 02/10/22 Survey Census: 78 Sample Size: 28	4 000		
4 118	11-94.1-27(7) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (7) The right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive; □ This Statute is not met as evidenced by: Based on record review, resident interview, staff interview, review of policy on Resident Rights regarding Treatment and Advance Health Care Directives (AHCD), the facility failed to provide information concerning the right to formulate an AHCD for three Residents (R) 24, 47, 65 out of twenty eight residents reviewed. Findings include: 1) Review of the Electronic Health Record (EHR) showed R24 was admitted on 11/10/21 with a	4 118	1. Immediate action(s) taken for the resident(s) found to have been affected include: The Advanced Directives status of RI# 24, 47, 65 was verified and entered into all relevant locations within the electronic medical record. Social Services Director or Designee to communicate with resident or family as applicable for changes or initiation of Advanced Healthcare Directives(AHCD). Documentation of that communication/education will be provided	3/22/22

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/11/22

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4 118	Continued From page 1 diagnosis of Urosepsis, Diabetes, Hypertension, Cerebral Vascular Accident, Atrial Fibrillation. There was also a physician order to provide Cardiopulmonary Resuscitation (CPR) if needed in emergency situations. During an interview with R24, on 02/08/22 at 10:00 AM, R24 stated that the facility did not offer anything about formulating an AHCD. On 02/08/22 at 10:30 AM, Social Worker (SW) was queried about providing R24 information to formulate an AHCD. SW stated that he/she was temporarily in the current staff position and that the previous staff member in charge of the AHCD information has since left. SW acknowledged that there was no documentation that R24 was provided any information concerning the right to formulate an AHCD. 2) On 02/10/22 at 09:55 AM, conducted a record review of R47's EHR. There was no documentation that R47 had an AHCD. A review of the resident's progress notes did not document that R47 (or resident representative) had an AHCD on file, was offered assistance with an AHCD, or refused assistance with formulating an AHCD. On 02/10/2022 at 11:30 AM, inquired with the SW regarding R47's AHCD. SW confirmed there was no documentation that R47 had an AHCD, was offered assistance with formulating an AHCD, or refused assistance with formulating an AHCD. 3) On 02/09/22 at 02:26 PM, R65's EHR was reviewed. R65 was admitted to the facility on 07/29/20. R65's "Face Sheet" under "Advanced Directives" stated that R65 was "Full Code" requiring "Full treatment" and that a copy of the	4 118	in the medical record. 2. Identification of other residents having the potential to be affected was accomplished by: Determining the code status or presence/absence of AHCD is required for all residents. Therefore, all residents have the potential to be affected. 3. The Director of Nursing Services educated social services staff and licensed nurses regarding the documentation procedures for Advance Directives/code status. A chart audit of all residents was completed on March 14, 2022. Discrepant findings were addressed immediately, and all needed actions were completed on March 18, 2022. Upon admission Social Services Director or Designee will educate and document in the medical record discussions with family or resident regarding completing Advanced Directives. Quarterly, residents and families who have not yet executed advanced directives, will be offered by Social Services Director or Designee. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: For a period of three months, the Director of Social Services or designee will perform weekly medical record audits of new admissions and those residents on the MDS assessment schedule for consistent documentation of the resident□s Advance Directive/code status throughout the electronic medical record. After three months, the Director of Social Services will complete a random medical	

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4 118	Continued From page 2 AHCD was on file. A copy of R65's AHCD was not found in R65's EHR. A review of facility policy on Resident ' s Rights regarding Treatment and Advance Directives stated the following: Policy, it is the policy of the facility to support and facilitate a resident ' s right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. Policy explanation and Compliance guidelines; 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. 4. The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities. 5. The facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant health care decisions. 6. The facility will define and clarify medical issues and present them to the resident or legal representative as appropriate ... 8. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. 9. Any decision making regarding the resident ' s choices will be documented in the	4 118	record audit of at least 10 records for consistent documentation. Results of the audits will be discussed monthly with the QAA committee until such time it is determined that substantial compliance is maintained. Corrective action completion date: By: March 22, 2022	

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4 118	Continued From page 3 resident ' s medical record and communicated to the interdisciplinary team and staff responsible for the resident ' s care ...14. The facility will use the process as provided by State law for handling situations in which the facility and/or physician do not believe that they can provide care in accordance with the resident ' s advance directives or other wishes.	4 118		
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	4 149	. Immediate action(s) taken for the	3/25/22

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4 149	Continued From page 4 reviews, the facility failed to ensure comprehensive care plans were developed and/or implemented for 4 of 18 Residents (R) 35, R76, R79, and R78. Findings include: 1) R35 was admitted to the facility on 10/16/20 with diagnosis that include cerebrovascular accident (stroke), anemia, epilepsy, dysphagia, quadriplegia, major depression disorder, and contracture to the right and left ankle. Review of R35's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/02/2021 documented in Section O, 0500 Restorative Nursing Programs, documented with in the last 7 days R35 had splint or brace assistance all 7 days. Conducted multiple observation (02/07/22 at 09:32 AM, 10:38 AM, 11:12 AM, 12:30 PM, and 1:30 PM; 02/08/22 at 8:40 AM, 10:32, 11:37, 12:28, and 1:30 PM; 02/10/22 at 08:15 AM, 09:15 AM, and 10:00 AM) of R35 in bed with no handrolls, splint, boot, brace, or appliance applied to prevent the worsening of contractures to both feet and hands. On 02/09/22 at 09:15 AM, conducted a record review of R35's electronic medical records (EMR). Review of the resident's care plan (started on 09/21/21) documented a history of stroke (which resulted in the resident not being able to move himself/herself willingly) with interventions to utilize foot boot to bilateral feet for contracture prevention and to utilize split to right hand for prevention of contractures. On 02/10/22 at 09:01 AM, conducted a concurrent observation and interview with	4 149	resident(s) found to have been affected include: Care plan(s) of the resident identifier(s) RI# 35, 76, 79, 78 were reviewed and updated as indicated. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that residents with 1) altered texture diets, 2) residents who require a hoyer lift for transfers, 3) residents who have splinting devices, and 4) all residents who receive Hemodialysis (HD) have the potential to be affected. Each resident impacted above will have their care plan reviewed by March 25, 2022. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility□'s policy and procedure for developing Comprehensive Care Plans. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing (DON), or designee, will complete random weekly audits of 3 resident care plans for six (6) consecutive weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents based on residents present needs. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the	

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4 149	Continued From page 5 Restorative Nurse Aide (RNA)1 regarding the application of foot boots to both feet and the right-handed splint. RNA1 confirmed that R35 did not have the boots or splint applied and should have. RNA1 stated the boots and splints should be put on for four (4) hours from 8:00 AM to 12:00 PM by the certified nurse aides and the restorative nurse aides are responsible to remove the boots and splint. At 09:05 AM, conducted an interview with Certified Nurse Aide (CNA) 6 who stated that it is the responsibility of the restorative nurse aides to apply the splints and boots. On 02/10/22 at 09:31 AM, conducted a concurrent interview while the Director of Nursing (DON) reviewed R35's EMR. This surveyor shared observations of no boots or splint applied to prevent the worsening of contractures for R35. After reviewing the resident's care plan the DON confirmed the boots and right-hand splint should have been applied to prevent the worsening of contractures for R35. Review of the facility's policy and procedure on 02/10/22 at 12:05 PM, Restorative Nursing Program, document identified residents will receive services from restorative nursing services that includes splint or brace assistance. 2) R76 was admitted to the facility on 01/22/22 after being discharged from an acute hospital for altered mental status, metabolic encephalopathy, and weakness. R76 has a history of high blood pressure, Diabetes Mellitus, and end stage renal disease with dialysis dependence. Review of R76's admission MDS with an ARD of 01/29/22, Section C. Cognitive Patterns, documented a Brief Interview for Mental Status (BIMS) was a 15, indicating R76 is cognitively intact. Section O.-Special Treatments and Programs document	4 149	Resident/Family Group Council for comment and suggestions. Corrective action completion date: March 25, 2022.	

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the resident has dialysis treatment.

During an interview with R76 on 02/08/22 at 09:46 AM, the resident reported staff do not weigh the resident and the access site is not assessed by staff when returning from dialysis treatment on Mondays, Wednesdays, Thursdays, and Fridays.

On 02/08/22 at 09:52 AM, query Nursing Staff (NS)1 regarding how staff documents their assessment of R76's access site and the resident's weight prior to and after the hemodialysis appointment. NS1 confirmed R76 is not weighed upon returning to the facility and assessment of the access site was not documented in the resident's progress notes for the 3:30 PM- 11:30 PM, and 11:30 PM - 07:30 AM shifts on 02/07/22 and 02/09/22.

On 02/08/22 at 3:45 PM, conducted a review of R76's EMR. Review of the resident's care plan documented on 02/07/22 and 02/09/22 review of the progress notes documented R76's access site was not assessed upon returning to the facility after dialysis treatment. Review of the resident's care plan documented R76 requires dialysis secondary to End Stage Renal Disease. Approaches include for staff to monitor the dialysis port and monitor R76's weight, both as prescribed. Review of the physician orders documented an order for post dialysis weight once a day on Monday, Tuesday, Wednesday, and Thursday 3:30 PM to 11:30 PM. (started on 02/01/22) and to assess the vascular access LAVF, document thrill and bruit, monitor for pain, bleeding three (3) times a day 07:30 AM- 3:30 PM; 3:30 PM- 11:30 PM, and 11:30 PM- 07:30 AM (started on 02/01/22).

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Review of the facility's policy and procedure on Hemodialysis, compliance guidelines, documented "7. The nurse will monitor and document the status of the resident's access site(s) upon returning from the dialysis treatment to observe for bleeding or other complications."

3) R79 was admitted to the facility on 01/28/22 with diagnosis that include traumatic subdural hemorrhage, prostate cancer, muscle weakness, and dysphagia (difficulty swallowing). Review of R79's admission MDS with an ARD of 01/31/22, Section K. Swallowing/Nutritional Status K0510.2. documented the resident is on a mechanically altered diet that requires change in texture of food or liquids (e.g., pureed food or thickened liquids).

On 02/07/22 at 12:45 PM, while conducting dining observations during lunch, observed R79's meal card documented Nectar thick liquids. On R79's lunch tray was a bowl of soup with regular (no thickener added) consistency and a cup of water which contained thickener but was not nectar thick consistency. Immediately alerted NS16, who confirmed the soup base should have been Nectar thick and although the water did have thickener in it, it was not the correct consistency. NS16 notified the Dietary Manager (DM) who also confirmed the soup and water was not Nectar thick consistency. Posted on the wall behind the R79's bed was a bright pink sign documenting with bullet points:

Resident's name
Must have thickened liquids
His swallowing is not normal
Watery liquids will go down his windpipe
Water, juice, milk, clear soup must all be thickened
Thickened liquids should be like nectar or watery

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syrup

On 02/08/22 at approximately 10:30 AM, conducted an interview with the Registered Dietician (RD). RD confirmed R79 has swallowing difficulties and requires Nectar thick liquids for aspiration precaution.

On 02/09/22 at 08:15 AM, conducted a record review of R79's EMR. Review of the resident's diet order documented Nectar thick liquids (started on 01/28/22). On 02/08/22, Speech Therapy (SP)1 evaluated R79 and recommended Nectar thick liquids. Review of the resident's care plan documented the resident is at risk for fluid and nutrition deficit related to dysphagia (underweight; poor intake, and stage IV prostate cancer). An approach to R79's fluid and nutrition risk included to provide the resident's diet as ordered: Regular diet, chopped solids, nectar thick liquids (started 01/31/22).

4) On 02/08/22 at 12:56 PM, CNA4 and CNA5 was observed using a Hoyer lift to transfer R78 from her wheelchair to her bed. R78 appeared to be alert and well nourished.

On 02/08/22 at 01:03 PM, CNA4 and CNA5 were interviewed. CNA4 and CNA5 both stated that R78 requires two people and a Hoyer lift to transfer R78 from her wheelchair to her bed.

On 02/08/22 at 02:04 PM, R78's record was reviewed. R78 was admitted to the facility on 07/01/21 for congestive heart failure. On 02/08/22, R78's weight was documented at 217.5 lbs. with a Body Mass Index (BMI) of 38.52 meaning that R78 is obese. R78's quarterly Minimum Data Set (MDS) review with an Assessment Reference Date (ARD) of 01/31/22,

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stated that R78 requires "Two Persons physical assist." when transferring to or from the bed, chair, wheelchair, or to a standing position. In "Progress Note" dated 10/28/21, Registered Nurse (RN) 2 documented, "Explained by PT (physical therapist) to resident that due to pain issues, would recommend use of Hoyer lift for safe transfers for now ...Resident agreed to try using Hoyer lift." Review of R78's care plan did not show documentation that R78 required using two people and a Hoyer lift for transfers.

On 02/09/22 at 09:32 AM, Unit Manager (UM) 2 reviewed R78's care plan. UM2 confirmed that there was no documentation in R78's care plan showing that R78 required two people and a Hoyer lift for transfers. UM2 stated, "It should be included in R78's care plan that R78 needs two people for transfers and a Hoyer lift."

On 02/09/22 at 11:05 AM, RN2 was interviewed. RN2 confirmed that R78 required two people and a Hoyer lift to transfer R78 to and from her bed to her wheelchair and that this requirement should have been included in R78's care plan.

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4 153	11-94.1-40(a) Dietary services	4 153		3/22/22

(a) The food and nutritional needs of the residents shall be met through a nourishing, well-balanced diet in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, and shall be adjusted for age, sex, activity, and disability.

(1) At least three meals shall be served daily at regular times with not more than a fourteen hour span between a substantial evening meal

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4 153	Continued From page 10 and breakfast on the following day; (2) Between meals nourishment that is consistent with the resident's needs shall be offered routinely and shall include a regular schedule of hydration to meet each resident's needs; (3) Appropriate substitution of foods shall be promptly offered to all residents as necessary; (4) Food shall be served in a form consistent with the needs of the resident and the resident's ability to consume it; (5) Food shall be served with appropriate utensils; (6) Residents needing special equipment, implements, or utensils to assist them when eating shall have the items provided by the facility; and (7) There shall be a sufficient number of competent personnel to fulfill the food and nutrition needs of residents. Paid feeding attendants shall be trained as per the facility's state-approved training protocol. This Statute is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure food was served in a form consistent with the needs of the resident and the resident's ability to consume the food for 1 Resident (R)79 sampled. R79 has difficulty swallowing and requires nectar thick liquid, but was served soup with a thin liquid consistency and water that was not thickened to nectar thick.	4 153	1. Immediate action(s) taken for the resident(s) found to have been affected include: the soup and water were immediately removed. Speech Therapy Referral and Assessment was completed to evaluate for acute consistency. Care plan of the resident identifier RI# 79, was reviewed and updated as indicated to reflect appropriate consistency.	

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4 153	Continued From page 11 R79 was admitted to the facility on 01/28/22 with diagnosis that include traumatic subdural hemorrhage, prostate cancer, muscle weakness, and dysphagia (difficulty swallowing). On 02/07/22 at 12:45 PM, while conducting dining observations during lunch, observed R79's meal card documented Nectar thick liquids. On R79's lunch tray was a bowl of soup with regular (no thickener added) consistency and a cup of water which contained thickener but was not nectar thick consistency. Immediately alerted NS16, who confirmed the soup base should have been Nectar thick and although the water did have thickener in it, it was not the correct consistency. NS16 notified the Dietary Manager (DM) who also confirmed the soup and water was not Nectar thick consistency. Posted on the wall behind the R79's bed was a bright pink sign documenting with bullet points: Resident's name Must have thickened liquids His swallowing is not normal Watery liquids will go down his windpipe Water, juice, milk, clear soup must all be thickened Thickened liquids should be like nectar or watery syrup On 02/08/22 at approximately 10:30 AM, conducted an interview with the Registered Dietician (RD). RD confirmed R79 has swallowing difficulties and requires Nectar thick liquids for aspiration precaution. On 02/09/22 at 08:15 AM, conducted a record review of R79's EMR. Review of the resident's diet order documented Nectar thick liquids	4 153	2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all resident who require thickened liquids have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Thickened liquid Policy along with the preparation procedure for thickened liquids will be in-service trained by Dietary Manager or Designee for dietary and nursing departments by March 18, 2022. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Dietary Manager, or designee, will complete daily audits X 1 week, weekly audits x 4 weeks, monthly audits x 3 months. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: March 22, 2022.	

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	125041	A. BUILDING: ______ B. WING ______	02/10/2022

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4 153	Continued From page 12 (started on 01/28/22). On 02/08/22, Speech Therapy (SP)1 evaluated R79 and recommended Nectar thick liquids. Review of the resident's care plan documented the resident is at risk for fluid and nutrition deficit related to dysphagia (underweight; poor intake, and stage IV prostate cancer). An approach to R79's fluid and nutrition risk included to provide the resident's diet as ordered: Regular diet, chopped solids, nectar thick liquids (started 01/31/22).	4 153		
4 158	11-94.1-40(f) Dietary services (f) The facility shall have a food service plan documented and available for department review that shall include but not be limited to the following: (1) Menus shall be written at least one week in advance; (2) Menus shall provide a sufficient variety of foods served in adequate amounts at each meal, and be adjusted for seasonal changes along with resident preference; (3) A different menu shall be followed for each day of the week. If a cycle menu is used, the cycle shall cover a minimum of four weeks; (4) All menus shall be filed and maintained with any recorded changes for at least three months; and (5) Menus shall be in place for at least three to five days of meal service in case of a natural or external disaster. A plan for meal service in the event of an internal disaster such as interruption of power or water supply shall also be in place	4 158		3/22/22

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4 158	Continued From page 13 and available for departmental review. This Statute is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sufficient variety of protein sources for breakfast. As a result of this deficiency, residents are at risk for nutritional deficiency due to a lack of variety of protein options for breakfast. Findings include: On 02/08/22 at 09:59 AM, during an interview with R76, the resident stated that eggs are served almost every breakfast, in one form or another. On 02/10/22 at 10:05 AM, conducted an interview with the Dietary Manager (DM)1. During the interview, DM1 confirmed that eggs are served often for breakfast, and stated that it is the primary source of protein for breakfast. At 12:00 PM on 02/10/22, reviewed a copy of the facility's meals for five weeks (Sunday-Saturday; breakfast, lunch, and dinner). The breakfast menu was reviewed for all five weeks, 30 of 35 five breakfast meals contained either scramble eggs (either alone or with green onions) or a hard-boiled egg; 4 days of hard-boiled and 26 days with scrambled eggs. The residents are served the same breakfast every Sunday that consist of cranberry juice, oatmeal, scrambled egg with green onion, and toast with margarine and jelly.	4 158	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident Food Preference was completed for resident #□s (10, 49, 38, 67 not found on resident list) and R#□s 80, 79, 76. Food preferences were updated within the medical record. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: March 18, 2022 the Dietary Manager in-serviced the dietary staff on the facility food preparation guideline for presentation. Dietary Manager and/or Dietician will evaluate alternatives to eggs to reduce the frequency of these items on the menu. Dietician will identify suitable alternative to the egg products. Resident Council will have the opportunity to review the menu for feedback and updating. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Dietary Manager or designee will conduct 2 x weekly food preparation and service audits x 4 weeks to ensure compliance. Further food preparation and service audits will be completed monthly	

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4 158	Continued From page 14	4 158	for 3 months. Audit results will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. By March 22, 2022	
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 observations, interviews, and review of facility policy, the facility failed to perform hand hygiene in between serving three residents their lunch meal. As a result of this deficient practice, the residents were put at risk for contracting communicable diseases or infections. On 02/07/22 at 11:58 AM, surveyor observed residents being served their lunch meal in the 2nd floor dining room. Certified Nursing Assistant (CNA) 3 was observed placing a tray on the table in front of a resident, taking the lids off the entrée and soup bowl, and placing the lids on a side table. CNA3 walked to the dining tray rack and then removed another lunch tray. CNA3 walked to another resident's table and placed the tray down in front of the resident. CNA3 took the lid off the entrée and pushed the resident's chair in.	4 203	1. Immediate action(s) taken for the resident(s) found to have been affected include: The certified nursing assistant (CNA # 3) was immediately in-serviced on proper hand hygiene procedures. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All personnel will be in-serviced on the facility□s policy for hand hygiene. In-service training includes random observation of personnel performing hand	3/22/22

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4 203	Continued From page 15 CNA3 then placed the entrée lid with the other entrée lids on a side table. CNA3 then took another tray from the dining tray rack and placed it on an empty table. CNA3 then walked across the room to a resident seated on a bench. CNA3 held the resident's arm as they both walked to the empty table. CNA3 helped resident sit in a chair and CNA removed lid from entrée. CNA3 placed entrée lid with other entrée lids on side table. CNA3 then performed hand hygiene with hand sanitizer. On 02/07/22 at 11:58 AM, CNA3 was interviewed. CNA3 stated, "I am supposed to sanitize my hands before and after setting up each meal tray." On 02/10/22 at 09:28 AM, Director of Nursing (DON) was interviewed. DON stated, "Hands should have been washed before and after setting up meal trays for each resident. That is our procedure." On 02/11/22 at 09:30 AM, a review of facility policy "Hand Hygiene" dated 02/10/22, stated that hand hygiene should be performed by employees between resident contacts.	4 203	hygiene procedures according to facility policy. Findings are reviewed with all personnel. Corrective action is provided as needed. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services (DNS), or designee, will complete random Validation Checklists of personnel and the timing and technique of hand hygiene procedure. To ensure personnel are performing the procedure in accordance with our facility□s Practice Guideline, random monitoring will occur each week for 4 weeks. Findings of this audit will be discussed with Resident Council. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: By March 22, 2022.	
4 220	11-94.1-55(g) Housekeeping (g) All combustible, potentially hazardous, or poisonous agents used for the cleaning of the facility shall be stored in a secured and locked area. This Statute is not met as evidenced by: Based on observations, staff interview, and review of policy, the facility failed to identify a potential accident hazard as evidenced by a	4 220	1. Immediate action(s) taken for the resident(s) found to have been affected include: The Administrator and the	3/22/22

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4 220	Continued From page 16 cabinet, that contained various chemical solutions, in the bathroom for rooms 202-204 not being secured with a padlock. As a result of this deficient practice, the facility put the safety and well-being of the residents at risk for chemical accident hazards. Findings include: During an observation of the shared bathroom for rooms 202-204 on 02/07/22 at 09:35 AM, a cabinet door was not secured with the attached padlock. The padlock was open and not locked and the cabinet could easily be accessed. The cabinet contained various chemical solutions including Tuberculocidal Spray Disinfectant, Micro-Kill Bleach Germicidal Wipes, and Selenium Sulfide Shampoo with urea and zinc pyrithione. Resident (R) 77 was seen walking with a walker near the unsecured cabinet and there was no staff in the immediate vicinity to prevent access to the chemical solutions that were in the unsecured cabinet. On 02/08/22 at 02:45 PM, the Administrator (Admin) was queried and stated that the cabinet door should have been locked, with the padlock, at all times. Review of policy on Environmental Services Safety Procedures stated the following: Policy, it is the policy of this facility to ensure general safety procedures are followed in the course of performing housekeeping and/or laundry duties. Policy Explanation and Compliance Guidelines ... Staff will ensure equipment (e.g. Cords, ladders, or chemicals) is properly stored and not left unattended in areas that are accessible to residents. When not in use, equipment will be stored in a locking closet, cabinet or storage area	4 220	Maintenance Supervisor met with the maintenance staff on February 9, 2022. All cabinets throughout the entire facility in were reviewed for any possible hazard to include: working secured combination lock on each cabinet. Any area of concern was corrected at that time. 2. Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected. The Maintenance staff reviewed all cabinets within the facility on February 9, 2022. Any area of concern was corrected. All cabinets are currently secure and are now inaccessible to residents. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Administrator and/or Maintenance supervisor will instruct all employees to report any issue with cabinets to the maintenance supervisor per the maintenance reporting system. All staff will be in-serviced on the policy and procedure on the facility policy for Accidents and Supervision. All resident falls/accidents will be reviewed daily by the nursing management team to ensure appropriate implementation of safety interventions including updating the plan of care. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The maintenance team will conduct routine cabinet checks weekly to ensure that all cabinets are in proper working order. Findings of routine	

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4 220	Continued From page 17 for safety.	4 220	bathroom cabinet checks will be documented and kept for further review. These audits will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: By March 22, 2022	