STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125050	A. BUILDING: _____ B. WING _____	10/06/2022

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HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

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4 000	Initial Comments A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 10/03/2022 to 10/06/2022. The facility was not in substantial compliance with Chapter 11-94, SKilled Nursing/Intermediate Care Facilities. Survey dates: 10/03/2022 to 10/06/2022 Census: 34 Sample size: 12	4 000		
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.	4 149		10/28/22

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4 149	Continued From page 1 This Statute is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to develop a care plan to address hand contractures for 1 (Resident #28) of 2 sampled residents who had hand contractures. This had the potential to affect 11 residents who had contractures, per the Resident Census and Conditions of Residents form dated 10/03/2022. Findings included: During an interview on 10/06/2022 at 3:57 PM, the Director of Nursing (DON) stated she was looking for a care plan policy. A care plan policy had not been provided as of the end of the survey. Review of an "Admission Record" revealed Resident #28 had diagnoses that included Alzheimer's disease. Review of an annual Minimum Data Set (MDS) dated 09/09/2022 revealed Resident #28 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. The MDS indicated the resident was totally dependent for activities of daily living (ADLs). According to the MDS, the resident had no functional limitation in range of motion in the upper or lower extremities. During an observation on 10/03/2022 at 10:30 AM, Resident #28 was in bed. Both hands had contractures. There was a rolled towel in the resident's left hand. No device was in place in the right hand. As of 10/03/2022, review of Resident #28's care	4 149	How the corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice - A comprehensive care plan policy was updated by the Admin and DON to ensure that all resident will have personalized care plan tailored to their individual needs - #28 the MDSC will ensure the resident have complete and accurate care plan that accurately reflect the residents status with personalized interventions. #28s care plan was updated with person-centered approaches in regards to the upper extremities contractures. How the facility will identify other residents having the potential to be affected by the same deficient practice - All current and new residents have the potential to be affected by the same deficient practice What measures will be put into place or systematic changes made to ensure that the deficient practice does not recur - A facility wide audit was completed to verify all residents who have contractures have accurate and person-centered approaches to their care plans related to the contracture - #28 the MDSC will update and revise the care plan and provide an in-service for all	

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4 149	Continued From page 2 plan revealed it did not address hand contractures or restorative nursing services. During an observation and interview with the DON on 10/05/2022 at 2:15 PM, the DON stated Resident #28's hands were not contracted and that the resident used hand rolls to protect the skin, because the fingernails touched the resident's palm. The DON attempted to demonstrate passive range of motion on Resident #28's hands but was unable to open them. The DON initially stated that Resident #28 was resisting but concluded after an additional attempt that the hands were contracted. The DON acknowledged Resident #28 had contractures in both hands. During an interview on 10/06/2022 at 2:55 PM, the Director of Nursing (DON) stated if a resident had contractures, this should be addressed on the care plan.	4 149	Certified Nurse Aides and nursing staff about interventions to prevent further contractures How the facility plans to monitor its performance to make sure that solutions are sustained - The MDSC will review the care plans of all residents who have contractures weekly to ensure that the care plan accurately reflects the goals and interventions in place to manage or improve contracture - As residents develop contractures via assessments or as residents are admitted with contractures, they will be added to the targeted list and this monitoring will continue for 4 consecutive weeks or until zero findings has been achieved - Contracture care plans will be monitored weekly for no less than 6 months to ensure ongoing compliance with contracture acre plans, then after that, random monitoring will occur and any issues/concerns will be addressed - A comprehensive care plan audit tool will be utilized for a quarterly review by the DON - The MDSC will in-service all nursing staff on the importance of proper documentation and accurate care planning that is personalized and will be reviewed by the DON, and any failure to follow in-service points will result in further education - At the monthly QAPI meetings, the results of the contracture care planning by the MDSC will be reviewed and any	

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4 149	Continued From page 3	4 149	concerns will be addressed and an action plan by the ID Team will be written and will be monitored by the Administrator weekly until resolved	
4 151	11-94.1-39(d) Nursing services (d) Should drug or medication administration be delegated pursuant to chapter 16-89, subchapter 15, there shall be documented evidence of a training program, individuals receiving training, and ongoing monitoring and evaluation to assess compliance with requirements. This Statute is not met as evidenced by: Based on document review, interviews, and facility policy review, the facility failed to ensure a nursing assistant (NA) who was a full-time employee completed the required competency exam for certification within four months of hire for 1 (NA #1) of 1 NA reviewed for competencies. Findings included: Review of the facility's staffing schedule for October 2022 revealed the facility employed a non-certified nursing assistant (NA #1) on a full-time basis. Review of an untitled and undated facility document with staff credentials and hire dates revealed NA #1 was hired 01/24/2022 and was not certified. During an interview on 10/05/2022 at 12:45 PM, the Director of Nursing (DON) was asked when NA #1 would be certified. The DON stated NA #1 was working on getting her certification, but the	4 151	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - The facility will not use any Nurse Aides (NA) to provide nursing related services. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All current and new residents have the potential to be affected by the same deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur. - All new employees hired to provide	10/28/22

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4 151	Continued From page 4 DON was not sure "what her plan is." The DON indicated she was not sure what training the NA had received or whether she had taken Certified Nursing Assistant (CNA) courses. The DON stated NA #1 assisted the CNAs with feeding, toileting residents, assisting with transfers, and changing incontinent briefs. During an interview on 10/05/2022 at 3:04 PM, the DON stated the Business Office Manager (BOM) was responsible for training and competencies, including verification of certification; however, the BOM was on vacation at this time. During an interview on 10/06/2022 at 8:20 AM, the DON stated the facility did not have a policy related to the use of NAs. During an interview on 10/06/2022 at 1:54 PM, NA #1 verified she was not certified and stated she had taken CNA classes but did not take the exam. She stated she was trained by another CNA on the proper way to bathe residents and change residents' incontinence briefs. The NA stated she assisted the CNAs as needed, with care such as manual and mechanical lift transfers, bathing, and changing incontinence briefs. She stated she assisted with activities and helped CNAs on the floor but not by herself. During an interview on 10/06/2022 at 2:55 PM, the DON was asked if she had located information regarding NA #1's training and stated she had not. The Administrator was unavailable for interview during the survey.	4 151	nursing related services will be certified. - The facility will not hire NAs. - The Office Manager will verify certification prior to employment. - The Office Manager was re-educated by the Administrator on 11/2/22 on the responsibility of verifying certification prior to employment. How the facility plans to monitor its performance to make sure that solutions are sustained. - NAs were previously accepted to provide nursing related services on a temporary basis. In the future, the facility will provide specific dates as to when they will be terminated or reassigned to a different position. - The Office Manager will monitor certification and recertifications of Certified Nursing Assistants (CNAs). - The Office Manager will monitor certification and recertifications of Certified Nursing Assistants (CNAs) and contact anyone with an upcoming expiration at 120 days, 90 days, 60 days, and 30 days, and also offer support in submitting application and process knowledge. An expired license or exceeding 120 days will result in termination. The Office Manager will audit the expiration files on a weekly basis for a period of 6 months and the findings of the audit will be reported to the ID Team during weekly Manager□s meeting and quarterly QAPI meeting to verify compliance.	

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4 152	Continued From page 5	4 152		
4 152	11-94.1-39(e) Nursing services (e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures. The policies and procedures shall include but not be limited to: (1) Written procedures for personnel to follow in an emergency including: (A) Care of the resident; (B) Notification of the attending physician and other persons responsible for the resident; and (C) Arrangements for transportation, hospitalization, or other appropriate services; (2) All treatment and care provided relative to the resident's needs and requirements for documentation; and (3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized This Statute is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure nursing care was provided in accordance with accepted standards of practice for Resident #2 and Resident #24. Specifically, the facility: - failed to ensure assistance with repositioning was promptly provided to promote comfort for 1	4 152	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - The nursing facility has put in place a positioning policy and procedure and the	10/28/22

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4 152	Continued From page 6 (Resident #2) of 1 sampled resident reviewed for positioning. - failed to ensure neurological (neuro) checks were consistently conducted and documented after an unwitnessed fall for 1 (Resident #24) of 3 sampled residents reviewed for accidents. Findings included: 1. During an interview on 10/06/2022 at 3:02 PM, the Director of Nursing (DON) stated she was looking for the facility's policy on positioning. No policy was provided by the end of the survey. Review of an "Admission Record" revealed the facility admitted Resident #2 on 06/07/2022 with diagnoses that included unspecified dementia with behavioral disturbance and history of falling. Review of a quarterly Minimum Data Set (MDS), dated 09/20/2022, revealed Resident #2 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. According to the MDS, the resident required extensive assistance with bed mobility, was totally dependent for transfers and locomotion, and did not walk. During an observation on 10/03/2022 at 1:06 PM, Resident #2 was sitting in a wheelchair. The resident had slid down into a slightly slouched position. During an observation on 10/05/2022 at 9:54 PM, Resident #2 was sitting in the wheelchair in a slouched position. The wheelchair was in the upright position, and Resident #2's feet were dangling above the floor. Further observations on 10/05/2022 revealed the following:	4 152	DON will in-service all nursing staff to ensure correct compliance with the policy. - #2 the MDSC will revise and update plan of care to include interventions for repositioning and a non-skid padding has been provided for the resident. - All Certified Nurse Aides will be educated on the use of non-skid padding on the resident (s) Geri chair. - Those residents in the last week/quarter with an unwitnessed fall have been reviewed to ensure they have had neurological assessments done. If neurological assessments were not performed, a neurological assessment were performed and any negative outcomes were communicated to the physician. - The nursing facilitys clinical guideline on Neurological Assessment has been reviewed and revised by the DON to clarify neurological monitoring for unwitnessed fall and witnessed fall when there is a head injury/trauma. - Nurses have been re-educated by the DON on the performance expectations to meet facilitys professional standards. - The DON will conduct weekly audits of all unwitnessed and witnessed falls will be completed for 4 weeks or until 100% compliance of neurological assessment compliance is achieved. How the facility will identify other residents having the potential to be affected by the same deficient practice. - Residents with poor posture and residents that exbibits restlessness will be	

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4 152	Continued From page 7 - At 10:00 AM, Certified Nursing Assistant (CNA) #2 approached the resident and adjusted the blanket but did not assist the resident to reposition in the wheelchair. - At 10:10 AM, Resident #2 attempted to scoot up in the chair. Activity Assistant (AA) #1 moved Resident #2's overbed table but did not assist the resident to reposition in the wheelchair. Resident #2 pushed on the arms of the wheelchair and attempted to scoot up in the chair but was unsuccessful. - At 10:21 AM, Resident #2 remained in the wheelchair. The resident's legs were elevated but the resident remained in a slouched position. The resident attempted to scoot up in the chair by pushing with one foot but was unsuccessful. During an interview on 10/05/2022 at 11:47 AM, CNA #3 and CNA #6 stated Resident #2 sometimes slid down in the reclining wheelchair, but that they would reposition the resident. During an observation on 10/06/2022 at 9:11 AM, Resident #2 was sitting in the reclining wheelchair with legs elevated. The resident had slid down in the chair, and the resident's lower back was resting on the wheelchair's seat. Further observations on 10/06/2022 revealed the following: - At 9:15 AM, Registered Nurse (RN) #1 approached Resident #2, gave the resident a blanket, and walked away without assisting the resident to scoot up in the chair. - At 10:34 AM, Resident #2 remained in a slouched position in the wheelchair, and the resident's lower back was resting on the seat of	4 152	affected by the same deficient practice. - A weekly plan of care updates review will be conducted by the MDSC, and interventions will be monitored by the charge nurse. What measures will be put into place or systematic changes made to ensure that the deficient practice does not recur. - The DON will conduct a random plan of care review on a quarterly basis to ensure that preventive measures are implemented. How the facility plans to monitor its performance to make sure the solutions are sustained. - A quarterly plan of care audit will be conducted by the DON. - Visual monitoring will be done by conducting routine rounds by the DON/designee and ID team members will discuss residents care needs with residents or representatives to ensure that residents are being repositioned in a timely manner. - Findings from the positioning and neuro check monitoring will be reviewed quarterly in the QAPI meeting.	

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4 152	Continued From page 8 the chair. During an interview on 10/06/2022 at 10:38 AM, CNA #3 was asked why the resident's back was positioned on the seat of the wheelchair. The CNA stated Resident #2 always slid down in the chair. When asked if any interventions had been attempted to assist the resident with maintaining a comfortable position in the chair, CNA #3 stated no but that she would try putting something in the chair. During an observation on 10/06/2022 at 10:49 AM, CNA #3 and CNA #4 repositioned Resident #2 and placed a rolled blanket under the resident's knees. During an interview on 10/06/2022 at 2:55 PM, the Director of Nursing (DON) stated if the resident was sliding down in the wheelchair, staff should have repositioned the resident. The DON stated a non-slip mat should have been placed in the chair to prevent the resident from sliding down. 2. Review of a facility policy titled, "Fall Protocol Policy," revised January 2005, revealed, "In case of fall, the following protocol/policy shall be applied: 1. Assess resident by the RN [Registered Nurse]; 2. Check for injuries; if applicable for First Aid intervention; 3. Report any noted injury to the Physician; 4. Report to the DON [Director of Nursing] or Administrator (if applicable); 5. Notify the family. 6. Apply First Aid as applicable and initiate Physician's orders/instructions; 7. Prepare incident report by the staff concerned; 8. Follow neurological protocol and monitor vital signs within 72 hours (if applicable) with required charting." Review of the attached, "Observation of Neurological Signs" policy (not dated) revealed,	4 152		

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4 152	Continued From page 9 "The purpose of this observation is to detect clinical manifestations of increased intracranial pressure [a rise in the pressure inside the skull that can result from or cause brain injury]." Additionally, the policy indicated neurological signs and vital signs were to be monitored every 15 minutes times (x) 4, then every 30 minutes x 2, then every four hours x 5. The policy included a blank copy of a "Neurological Assessment Flow Sheet," which included instructions for completing the neuro checks, including checking the resident's level of consciousness, pupil response, motor functions, pain response, and vital signs. Review of an "Admission Record" revealed Resident #24 had diagnoses that included neurocognitive disorder with Lewy bodies (decreased mental function due to abnormal build-up of proteins into masses known as Lewy bodies) and malignant neoplasm of the brain (brain cancer). Review of a quarterly Minimum Data Set (MDS), dated 08/31/2022, revealed Resident #24 was severely impaired in cognitive skills for daily decision-making per a staff assessment of mental status. The MDS indicated the resident required extensive assistance with bed mobility and transfer and had no falls since admission, reentry, or the prior assessment. Review of an "Incident Report," dated 02/23/2022, revealed Resident #24 had an unwitnessed fall. The probable cause was a sit/slide from bed. No injuries were noted. The section of the report titled, "Medical/Emergency Actions/Administered" included an option to check that neurological monitoring was initiated; however, this option was not checked. There was no "Neurological Assessment Flow Sheet" with	4 152		

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4 152	Continued From page 10 the Incident Report. During an interview on 10/05/2022 at 2:45 PM, Registered Nurse (RN) #2 stated he was working when Resident #24 fell on 02/23/2022. RN #2 stated the resident's family had gone home, and the resident was restless. Staff had just provided incontinence care about 30 minutes prior to the fall. RN #2 stated neurological checks were started and were done every 15 minutes for the first hour and then "went from there." Review of "Progress Notes" revealed the following: - The note dated 02/23/2022 at 9:50 PM, revealed a Certified Nursing Assistant (CNA) reported the resident was "on the ground" at 8:28 PM. Upon the nurse's arrival to the room, the resident was lying beside the bed crying for help. The resident was assessed, and no injury was noted. The resident was placed back in bed. The note did not address whether neuro checks were initiated. The next "Progress Note" in the clinical record was dated 02/24/2022 at 2:47 AM. - The "Progress Note" dated 02/24/2022 at 2:47 AM indicated there was no change in the resident's level of consciousness; no other information related to neuro checks was included in this note. The next "Progress Note" in the clinical record was dated 02/24/2022 at 12:59 PM. - The "Progress Note" dated 02/24/2022 at 12:59 PM indicated, "Continue neuro check." The note indicated the resident was alert and that the blood pressure was 96/52. No other neurological assessment information was included. There were no further "Progress Notes" referencing	4 152		

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4 152	Continued From page 11 neuro checks related to the resident's fall on 02/23/2022. During an interview on 10/06/2022 at 9:47 AM, RN #1 stated when a resident had an unwitnessed fall, there should be neurological checks, even if the resident looked okay. During an interview on 10/06/2022 at 8:20 AM, the Director of Nursing (DON) stated she was attempting to find a "Neurological Assessment Flow Sheet" for Resident #24 but did not know where it was. The DON stated neurological checks should have been done. The Administrator was not available for interview during the survey.	4 152		
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 and interviews, the facility failed to ensure staff implemented appropriate infection control practices during 3 of 3 meals observed. Specifically, staff opened and handled residents' straws and chopsticks with their bare hands while preparing residents' beverages and setting up residents' meal trays. Findings included:	4 203	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Employees watched training videos that were sent with letter from the Department of Health - Videos that were watched included	11/1/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MALAMALAMA	6163 SUMMER STREET HONOLULU, HI 96821

(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
4 203	Continued From page 12 On 10/05/2022 at 4:30 PM, Activity Aide (AA) #1 was observed placing straws in two beverages on a resident's meal tray with her bare hands, touching the ends that would go into the resident's mouth. On 10/06/2022 at 7:09 AM, Registered Nurse (RN) #1 was observed preparing water and juice for a resident. RN #1 opened straws and placed them in the cups, touching the straws at the ends that would go into the resident's mouth with bare hands. On 10/06/2022 at 11:17 AM, Certified Nursing Assistant (CNA) #1 was observed opening disposable chopsticks for Resident #15; CNA #1 touched both ends of the chopsticks with bare hands before giving them to the resident. On 10/06/2022 at 11:21 AM, CNA #1 opened straws for two drinks for a resident and touched the ends of the straws with bare hands before placing them in the drinks. On 10/06/2022 at 11:26 AM, AA #1 prepared three drinks for a resident and touched the end of one of the straws with bare hands before placing it in one of the drinks. On 10/6/2022 at 11:30 AM, RN #1 prepared two drinks for a resident and touched the ends of the straws with bare hands before placing them in the drinks. During an interview on 10/06/2022 at 2:55 PM, the Director of Nursing (DON) stated that when straws and chopsticks were opened, the two ends should not be touched.	4 203	Sparkling Surfaces, Clean Hands, Keep COVID-19 Out!, and PPE Lessons - Employees signed attendance sheet showing that they watched all the videos How the facility will identify other residents having the potential to be affected by the same deficient practice. - All current and new residents have the potential to be affected by the same deficient practice What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur. - Infection control in-services will be continue to be conducted, with information included regarding infection control for dining practices. This includes hand hygiene, and proper handling of utensils or condiments in a sanitary manner. - If an employee is unable to correctly demonstrate how to unwrap utensils or how and when to perform hand hygiene, the proper method will be demonstrated. How the facility plans to monitor its performance to make sure that solutions are sustained. - The office manager, social work designee, or another designated employee will monitor dining related infection control practices at least monthly. - On-the-spot coaching will be provided for	

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4 203	Continued From page 13 The Administrator was not available for interview during the survey.	4 203	staff that do not perform these tasks properly. - In-services on infection control and prevention and how infections can spread throughout the facility will be conducted annually and as needed when problems are identified or new emerging infectious disease of concern are identified.	
4 214	11-94.1-55(a) Housekeeping (a) Each facility shall have a plan for routine periodic cleaning of the entire building and premises. □ This Statute is not met as evidenced by: Based on observations, record review, interviews, and facility policy review, the facility failed to provide a homelike environment for 3 (Residents #9, #22, and #24) of 34 residents whose rooms were observed. Specifically, the facility failed to ensure the shared room of Residents #9, #22, and #24 was not used for storage of supplies and equipment. Findings included: Review of a facility policy titled, "Safe/Clean/Comfortable/Homelike Environment Policy," dated 1/2012, revealed, "The facility must provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible." Review of a quarterly Minimum Data Set (MDS), dated 07/27/2022, revealed Resident #9 was severely impaired in cognitive skills for daily	4 214	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - The extra bed in the room were subsequently cleared of the cardboard boxes and the mechanical lift was relocated to a storage unit. - The DON and ID Team discussed with Bristol Hospice and all hospice supplies were moved to a new storage unit designated only for hospice supplies. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents using medical equipment have the potential to be affected by the	10/28/22

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4 214	Continued From page 14 decision-making per a staff assessment for mental status. Review of a quarterly MDS, dated 08/26/2022, revealed Resident #22 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. Review of a quarterly MDS, dated 08/31/2022, revealed Resident #24 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. Observation on 10/03/2022 at 11:06 AM revealed the 4-bed room shared by Residents #9, #22, and #24 was being used for storage. The extra bed in the room had cardboard boxes stored on it, and a mechanical lift was also stored in the room. Observation on 10/04/2022 at 9:27 AM revealed the room shared by Residents #9, #22, and #24 continued to be used for storage. There was a large unopened box of incontinence briefs on the nightstand and two large boxes of briefs on the extra bed in the room. The mechanical lift also remained in the room. Observation on 10/05/2022 at 10:19 AM revealed a closet in the room shared by Residents #9, #22, and #24 was being used to store incontinence briefs, pads, perineal cleanser, shampoo and body wash, oxygen equipment, wipes, gauze pads, abdominal (ABD) pads, and suction kits. During an interview on 10/05/2022 at 10:17 AM, Certified Nursing Assistant (CNA) #1 stated the closet in the room shared by Residents #9, #22, and #24 was used as a hospice stock room for all the residents in the building who required those supplies, and the mechanical lift was stored in the	4 214	same deficient practice. - The Office Manager and SWD made rounds throughout facility to ensure no other resident rooms were being used as storage and will continue to make quarterly rounds or until compliance is achieved. What measures will be put into place or systematic changes made to ensure that the deficient practice does not recur. - The housekeeping and nursing staff will be re-in serviced on the policy and procedure for storage of medical equipment by the housekeeping manager. How the facility plans to monitor its performance to make sure that solutions are sustained. - A bi weekly audit of the cleaning and storage of medical equipment will be done by the housekeeping manager for the next 6 months and the results of the audit will be reported to the administrator and at the QAPI meeting by the housekeeping manager for any comments and recommendations for the next 6 months.	

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4 214	Continued From page 15 room for use by all residents in the building who required mechanical lift transfers. During an interview on 10/06/2022 at 9:05 AM, the Social Services (SS) employee stated the room shared by Residents #9, #22, and #24 was used for hospice storage. The SS stated since the facility did not have storage space for hospice, they decided to use the empty bed in the residents' room for storage. SS acknowledged the use of the room for storage did not contribute to a homelike environment. During an interview on 10/06/2022 at 2:55 PM, the Director of Nursing (DON) stated she was not aware the shared resident room was being used for storage. She stated residents' rooms should not be used for storage. The Administrator was not available for interview during the survey.	4 214		