Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125002	A. BUILDING: _____ B. WING _____ RECEIVED	10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILO MEDICAL CENTER	1190 WAIANUENUE AVENUE HILO, HI 96720

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4 000	11-94.1 Initial Comments A State licensure survey was conducted at the facility from 10/27/2015 through 10/30/2015. The facility is licensed for 119 beds. The resident census was 66 at the survey entrance.	4 000		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on a dining observation and staff interview, the facility failed to distribute drinks during dining service under sanitary conditions. Findings include: [redacted]	4 159	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Hilo Medical Center Extended Care Facility does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. It is submitted solely as the facility's credible allegation of compliance as mandated by Federal and State regulations. It is the policy of Hilo Medical Center that each Resident is treated as an individual with dignity and respect." **4 159 11-94. 1-41(a) Storage and Handling of food.** **Corrective actions for residents affected:** The Recreation Aide in question self-identified [redacted] mistake and immediately washed [redacted] hands at hand sink in dining area on 10/27/15. **Identifying other residents having the potential to be affected, and what corrective action will be taken:** Staff who provide assistance to Residents during dining or daily needs were provided with re-education about serving food under sanitary conditions including hand washing hygiene by the Director of	11/18/15

12.7.15 emailed LT

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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 and staff interviews, the facility failed to implement procedures to maintain an infection control program to prevent the spread of infection. Findings include: [redacted]	4 203	Staff Development on 11/18/15. Issues identified were addressed with staff and Dining Room monitoring will continue to watch for compliance during meal service. **Measures and systemic changes to prevent recurrence:** • Dining room coordinator daily meal monitoring sheet was updated on 11/16/15 to include monitor for hand hygiene practices. The checklists will continue to be reviewed and monitored by Administrator. **Monitoring Corrective action:** • The daily meal monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by Administrator to assure ongoing compliance and prevention of recurrence. **4 203 11-94. 1-53 (a) Infection Control. Corrective Actions for residents affected:** • Staff who did not don personal protection equipment correctly was immediately made aware on 10/28/15 and 10/29/15. The Housekeeping and Activity staff involved was re- educated regarding the findings by the Director of Nursing Services.	11/18/15

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4 203	Continued From page 2 [redacted]	4 203	**Identifying other Residents having potential to be affected, and what corrective action will be taken:** Staff have been re-educated on Isolation Procedures and the requirements and the need for proper use of Personal Protective Equipment (PPE) on 11/18/15 by the Director of Staff Development. **Measures and systemic changes to prevent recurrence:** • Quality Committee will continue to perform rounds to review compliance for hand hygiene and Personal Protective Equipment use when required. This report will be reviewed at the Monthly Quality Assurance Performance Improvement Committee by the Infection Control Nurse. **Monitoring Corrective action:** • The hand washing and (PPE) Personal Protective Equipment use report will be discussed at Quality Committee and monitored by the Infection control nurse and Director of Nursing services for ongoing compliance to prevent recurrence.	11/18/15
4 246	11-94.1-64(d) Engineering and maintenance (d) The facility shall maintain records that document that inspection of all devices essential to the health and safety of residents and personnel shall be carried out at sufficient intervals to ensure proper operational performance. This Statute is not met as evidenced by: Based on observation, staff interview, and policy	4 246	**4 246 11-94. 1-64 (d) Engineering and Maintenance** **Corrective actions for resident affected:** • The hanging surge protector was removed from facility on 10/29/15. The surge protector was replaced with a maintenance	

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4 246	Continued From page 3 review, the facility failed to maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. Finding includes: [redacted]	4 246	approved and labeled surge protector that same day. **Identifying other residents having the potential to be affected, and what corrective action will be taken:** Maintenance Worker performed full house rounds on 10/29/15 to assure that all surge protectors and small appliance connections met the HMC requirements for inspection and labeling. Staff were re-educated by the Director of Staff Development on the Facility Policy and Procedure -Use of Electrical Equipment on 11/18/15. **Measures and systemic changes to prevent recurrence:** Staff Development Director will continue to perform monthly Safety rounds and these rounds have an additional area to address the safety with regards to electrical devices and inspection for compliance. The Director of Nursing and Administrator will audit for compliance through rounding. **Monitoring Corrective action:** The Director of Staff Development will provide Safety report to the Quality Assurance Performance Improvement Committee monthly to assure the effectiveness of the protocol and procedure. Monitored, by the Administrator and Performance Improvement Committee, for trends.	11/18/15
4 278	11-94.1-65(e)(5) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (5) Multi-resident bedrooms shall provide a minimum of eighty square feet per bed of usable space, excluding closets, bathrooms, alcoves, and entryways;	4 278		

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4 278	Continued From page 4 This Statute is not met as evidenced by: Based on administration interview, the facility failed to ensure that multiple resident rooms measure at least 80 square feet per resident. Findings include: The facility has 23 rooms (4 beds in each) which do not meet the minimum 80 square foot per resident requirement. The following rooms did not meet the requirement: - Pakalana (North): Rooms 1, 3, 4, 5, 6, 7, 8, 9, 10, & 11 - Pua Melia (East): Rooms 1, 3, 7, & 9 - Pikake (South): Rooms 1, 2, 3, 4, 5, 6, 8, 9, & 11 During the entrance conference on 10/27/2015, the Administrator confirmed that the facility continues to have resident rooms not meeting the size requirement. [redacted] stated that the facility is old and no construction is scheduled to enlarge these rooms.	4 278	**4 278 11-94. 1-65 (e) (5) Construction Requirements.** **Corrective actions for Residents having the potential to be affected, and what corrective action will be taken:** • Residents have been re-assigned to all have rooms where there are only 3 beds in any room effective 11/23/15. Social worker has spoken with each Resident and Family Member and there was total agreement, this was documented in the Electronic Medical Record and included notification of any new roommates and each Resident's Physician by Licensed Nursing staff. **Identifying other Residents having the potential to be affected, and what corrective action will be taken:** • New admissions will not be placed in rooms with any more than three residents moving forward to allow for compliance with construction requirements. **Measures and systemic changes to prevent recurrence:** • Admitting nurse and licensed nurses were in-service trained 11/23/15 by Administrator on the 3 Resident to a room maximum to meet the construction requirement ongoing.	11/23/15
4 283	11-94.1-65(g)(1)(2) Construction requirements (g) The facility shall ensure that floors and walls are maintained as follows: (1) Floor coverings shall be of slip resistant material that does not retain odors and is flush at doorways; and (2) Walls, floors, and ceilings of rooms used by residents shall be made of materials that shall	4 283		

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4 283	Continued From page 5 permit washing, cleaning, and painting. This Statute is not met as evidenced by: The facility failed to ensure that bathroom floors are maintained to provide a safe, functional, sanitary, and comfortable environment for residents. Findings include: [redacted]	4 283	**Monitoring corrective action for sustained corrections:** • The daily census will be reviewed at QAPI meeting monthly to assure that no more than 3 Residents are placed in the affected bedroom rooms that do not meet the 80 square foot per resident requirement. Monitored by Administrator. **4-283 11-94. 1-65(g) (1) (2) Construction Requirements** **Corrective Actions for residents affected:** Flooring in North Room #4 and Room #9 and bathrooms on South Wing were deep cleaned by Housekeeping to clear brown patches 11/6 2015. Maintenance Department contacted Contractor who has given project estimate for bathroom floor covering replacement. **Identifying other residents having the potential to be affected, and what corrective action will be taken:** Maintenance Department has Completed full rounds of facility bathrooms and findings were included in Contractors job scope and specifications. **Measures and systemic changes to prevent recurrence:** Contract work completion will prevent recurrence. **Monitoring Corrective action:** Maintenance Department will monitor Contract work for completion/compliance.	12/14/15