FORM APPROVED

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
AMENDED POC	125010	A. BUILDING _____ B. WING _____	07/29/2016

RECEIVED
2016 SEP 26 P 3:25
STATE OF HAWAII
DEPT OF HUMAN SERVICES

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	11-94.1 Initial Comments A state relicensure survey was conducted at the facility from 7/26 - 7/29/2016. At the time of the entrance the resident census was 112,	4 000		
4 102	11-94.1-22(d) Medical record system (d) Records to be maintained and updated, *as* necessary, for the duration of each resident's stay shall also include; (1) Appropriate authorizations and consents for medical procedures; (2) Records of all periods, with physician orders, of use of physical or chemical restraints with justification and authorization for each and documentation of ongoing assessment of resident during use of restraints; (3) Copies of initial and periodic examinations and evaluations, as well as progress notes at appropriate intervals; (4) Regular review of an overall plan of care setting forth goals to be accomplished through individually designed activities, therapies, and treatments, and indicating which professional services or Individual is responsible for providing the care or service; (5) Entries describing all care, treatments, medications, tests, immunizations, and all ancillary services provided; and (5) All physician's, physician assistant's, or APRN's orders completed with appropriate documentation (signature, title, and date).	4 102	Nursing will assess residents found to have been affected by this deficient practice, including: • Immediate process- check MD orders, documentation before MD leaves unit and write an order clarification if needed. • Medical Director made contact with MD #1 via email advising of the importance of legibility in all documentation and asking for cooperation in this matter. • Medical Director and Administrator – follow up letter sent to MD#1 reviewing the Summary of Deficiencies in regard to legibility of orders with an initial proposal for review and input. MD#1 will be asked to type all orders when visiting the facility. • Nursing will document any oral clarification of orders by documenting these clarifications as a separate order in the resident's chart. Nursing will identify other residents having the potential to be affected by this deficient practice, including: • HIM will assist in ongoing assessment with Medical Director as head of Medical Records Committee (MRC), implement necessary procedures, and take necessary actions as needed at the administrative level.	8/17/16 & ongoing 8/22/16 9/12/16 Ongoing 8/23/16

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE	TITLE	(X6) DATE
Reid Ueda	Interim Administrator	9/22/16

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LEAHI HOSPITAL	**3675 KILAUEA AVENUE** HONOLULU, **HI 96816**

(X4) ID PREFIX TAO	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
4 102	Continued From page 1 This Statute is not met as evidenced by: The facility failed to ensure that the facility maintained accurate, complete and organized clinical information for 1 or 34 residents in the Stage 2 resident sample. Finding includes:	4 102	Medical Director, Admin, DON, HIM will identify other residents having the potential to be affected by this deficient practice, including: • Medical Director and Administration - General letter will be sent to all providers at Leahi regarding citation and importance of legibility of all documentation and orders. • Medical Records Committee (MRC) will also identify other providers that have consistent legibility issues in their medical record documentation. A separate letter to these providers notifying them of this issue and the requirement of improvement will be sent by the Medical Director and Administration. *(continue on addendum pages 2A-2B)*	9/12/16 8/23/16
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;	4 115	All residents' privacy curtains were inspected by the Head Nurse and Maintenance. Curtain rods were checked and repaired; bedside tables were rearranged to allow privacy curtains to close completely. *(continue on page 3)*	8/03/16

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LEAHI HOSPITAL.	**3675 KILAUEA AVENUE** HONOLULU, **HI 96816**

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4 102	Addendum to page 2	4 102	Nursing units will implement immediate measures to ensure that this deficient practice does not recur, including: • Review MD orders currently and do order clarifications before MD leaves unit to ensure comprehension and legibility. • HIM and IT will be dropping temporary form templates on each unit's work stations for MDs to type their orders and discharge summaries on. MDs will print and sign and forward to nursing staff. Training time – 3 days. IT, HIM, Medical Director, Admin and DON will implement measures to ensure that this deficient practice does not recur, including: • IT will provide computer access on each unit for any provider identified in the future as having consistent issues with legibility. These computers will be used by providers to access, type and print provider orders on each of their residents. • HIM will create a folder for Provider order sheet (and discharge summaries) • MD#1 will type, print out a copy of orders while visiting residents in the facility. • Soft copy of discharge summary form will be set up for use by MD#1 and any other provider identified with consistent legibility issues. They will be asked to type their discharge summary, print, sign and fax back to facility.) *(continue on page 2B)*	9/12/16 & ongoing 9/12/16 9/12/16 & ongoing 9/12/16 & ongoing 9/12/16 & ongoing 9/12/16 & ongoing

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AMENDED POC	125010	E. BUILDING: F. WING	07/29/2016

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4 102	Continued from page 2A	4 102	• Providers that have been identified by the MRC will have another letter sent to them specifically addressing legibility of their documentation and requesting improvement. If they do not show improvement they will be asked to type their orders and other patient documentation noted to be illegible.	Ongoing
			• Leahi Administration is in the process of requesting for proposals for an EMR system to be used at Leahi.	Ongoing
			• All nursing requests for clarification of orders given by providers will be documented by a separate order written by the nurse who receives the clarification.	Ongoing
			Medical Director, Administration, DON and QAPI committee will monitor corrective actions to ensure effectiveness of these actions, including:	
			• Unit Manager's will do monthly chart audits for the next 6 months of MD#1's (and any other providers identified) documentation of orders to ensure compliance with legibility.	Ongoing
			• DON to report deficiencies to the quarterly QAPI committee meetings, who will refer findings to Medical Director and Administration for further corrective action.	Ongoing
			• Long term resolution: HIM, Corporate and Regional IT in process of build and design of a comprehensive system based solution and partial electronic health record to be implemented within 45 days which will encompass and provide solutions to all of the above concerns including provide at any point/real time reports for various monitoring and ease of access.	9/12/16

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4 115	Continued From page 2 This Statute is not met as evidenced by: The facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of other individuality. Findings Include:	4 115	Head Nurse/charge nurse will continue to assess all residents having potential to be affected by this deficient practice including: • Visual observations of resident care areas daily to ensure privacy curtains are completely drawn/closed during care. • Random room and bedside checks daily to ensure that privacy curtains are not blocked by furniture • Re-educate/remind staff during shift reports of the importance of providing privacy to residents at all times. • Head Nurse/charge nurse to ensure compliance of corrective actions are effective by random bedside observations on a daily basis. Conduct weekly audits utilizing the Data Collection Tool with results reported quarterly at the QAPI committee meeting. Any further actions/recommendations will be shared with staff.	Ongoing Ongoing Ongoing Ongoing

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4 115	Continued From page 3	4 115 **4 136**	The resident's side tables were moved to allow privacy curtains to close properly.	7/30/16
			(Mail) The Facility has taken corrective action to address the this deficient practice, including • A representative from Leahi hospital (the Activity Director) was tasked by the Facility Administrator to coordinate Saturday mail service. • Contacting the USPS Kahala Branch manager to initiate mail service for Saturday's. • The USPS Branch manager sent out a representative to audit the site and provide information to begin Saturday mail service. *(continue on addendum pages 4A-4B)*	8/3/2016 8/5/2016 8/9/2016
4 136	**11-94,1-30 Resident care** The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to:		(See Page 5)	

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4 115	Continued From page 4	4 115	• With the recommendations of the post offices representative the facility constructed a mail box for use of Saturday USPS mail service. The box is located in the front of the main entrance of the hospital. • Saturday Mail service is scheduled to begin on 9/10/2016 Since the findings would affect all of the residents who are utilizing mail service, the Facility has taken the corrective actions as follows. • Constructed a mail box for Saturday mail service • Arranged for Saturday mail service to begin on 9/10/16 The following measures will be put into place to ensure the deficient practice dose not recur: • The USPS will begin Saturday mail service on: 9/10/2016 • The Saturday Activity staff will retrieve the resident's mail from the mail box and deliver it each unit for distribution. • The Social Worker will discuss Saturday mail service during the Resident council meeting's, to get a sample of resident's input regarding Saturday mail service. • The Activity Coordinators and the Activity Director will query the residents during the Annual Activity Profile and Assessment regarding mail service at Leahi. The following will be monitored to ensure the deficient practice dose not recur and that Saturday mail service is happening to the residents satisfaction, including: *(continue on addendum page 4B)*	8/9/2016-8/17/2016 9/12/2016 8/16/2016 9/10/2016 9/10/2016 Ongoing Ongoing Ongoing

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4 115	Continued From page 4A	4 115	• The Activity Director will monitor the resident's satisfaction with Saturday mail service via QA audits from the information gathered from the annual Activity Profile and Assessment.	Ongoing
			• Findings of QA audits and measurements will be shared in staff meetings for actions and recommendations to improve this practice.	Ongoing
			• Results of the resident council meetings and RT QA audits will be reported to the facility's QAPI for further action and recommendations.	Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER(CLLA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 136	Continued From page 4 (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fell prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on observations, staff Interviews and record review, the facility failed to ensure that each resident receive and is provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 2 of 34 residents included in the Stage 2 survey sample. Finding includes:	**4 138**	Licensed staff that were assigned to Res #58 when there were no documentation on the assessment of the were re-educated on the importance of checking each shift and timely documentation of the assessment. Each unit will identify all residents with vascular access device and they will be identified on resident roster for each unit. The residents with vascular access device listing will also be available in the treat-ment record with a reminder to check the vascular access device each shift for pa-tency, bruit, thrill and signs of infection, and to document their assessment in the treatment record. Reeducation on the facility's policy "Guide-lines for Nursing Care of Hemodialysis Resident/Patient" will be given to all licensed staff. This education will also discuss the importance of timely docu-mentation. The Head Nurse of each unit will conduct random audits of the treatment record with emphasis on the resident ensuring proper and timely documentation of assessments. The results of the random audits will be reported in the quarterly QAPI meetings.	08/19/16 8/19/16 09/12/16 Ongoing 7/30/16 & ongoing

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4 136	Continued From page 5	4 136	The case manager/licensed nurse will update care plans in a timely manner when the wound status changes. Each unit will identify all residents with wounds and perform weekly wound assessments with a photo and revise care plans and wound care as indicated in Care Plan. MDS will reflect wound changes. May consult with Wound Care Nurse.	8/18/16
			The HN/case manager/licensed staff and Wound Care Nurse will conduct random audits of care plans to ensure proper services are being done to achieve the highest level of well-being.	Ongoing
			(Gloves) - The Wound Care Nurse will re-educate licensed staff on hand hygiene as stated in the Oahu Region Hand Hygiene policy (ORIC002). Mandatory attendance of education sessions will be taken.	8/18/16
			Power Point on Wound Care Procedures presentations will be accessible online with the nursing Supervisor/HNs to ensure all licensed staff view and sign the attendance sheet. Education department will maintain these records.	Online education due 9/12/16
			The HN and/or Wound Care Nurse will conduct random audits of clean dressing technique including sanitizing hands in between glove changes and appropriate treatment procedures.	Policy review due by 9/12/16 & Ongoing

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4 136	Continued From page 6	4 136	(Application of topical medicine) – The Wound Care Nurse will re-train licensed nurses on clean wound care procedure, including using cotton tipped applicators for applying topical medicine. Mandatory attendance of education sessions will be taken.	8/18/16
			Power Point on Wound Care Procedures presentations will be accessible online with the nursing Supervisor/ HNs ensuring all licensed staff view and sign attendance sheet. Education department will maintain these records.	Online education due by 9/12/16
			(Gloves) - The Wound Care Nurse will re-educate licensed staff on hand hygiene as stated in the Oahu Region Hand Hygiene policy (ORIC002). Mandatory attendance of education sessions will be taken.	8/18/16
			Power Point on Wound Care Procedures presentations will be accessible online with the nursing Supervisor/HNs to ensure all licensed staff view and sign the attendance sheet. Education department will maintain these records.	Online education due 9/12/16
			The HN and/or Wound Care Nurse will conduct random audits of clean dressing technique including sanitizing hands in between glove changes.	Policy review due by 9/12/16 & Ongoing
			(Application of topical medicine) – The Wound Care Nurse will re-train licensed nurses on clean wound care procedure, including using cotton tipped applicators for applying topical medicine. Mandatory attendance of education sessions will be taken.	8/18/16

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4 136	Continued From page 7	4 136	Power Point on Wound Care Procedures presentations will be accessible online with the nursing Supervisor/ HNs ensuring all licensed staff view and sign attendance sheet. Education department will maintain these records.	Online education due by 9/12/16
4 145	11-94.1-38(a) Activities (a) The facility must provide for an ongoing program of age-appropriate activities designed to meet the interests, physical, mental, and psychosocial well-being of each resident.	4 145	The Unit Nurse Manager, Activity Director and Unit Activity Coordinator will assess these residents found to have been affected by this deficient practice to modify their setting or routine as needed:	

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4 145	Continued From page 8	4 145		8/03/16
	Findings Include:			8/05/16
				8/12/16
				8/12/16
				8/12/16

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4 145	Continued From page 9	4 145		8/12/16
				8/18/16
			The Activity Director and Unit Activity Coordinators will identify other residents having the potential to be affected by this deficient practice including: • The Activity Director and Activity Coordinators will compile a list of current residents that would be considered, "at risk" of isolation related to the inability to express their needs, impaired cognition, issues with mood and/or behaviors and modify their care plans as needed; including reviewing of care plans and the need for these residents to be scheduled for appropriate OOB activities on a weekly basis.	9/05/16
			• For future admissions, the Activity Coordinators and Activity Director will determine if a resident would be considered as, at risk for isolation related to the inability to express their needs, impaired cognition, issues with mood and/or behaviors. They will create activity based care plans with both 1:1 bedside activities and group activities; including the need for the resident to be scheduled for appropriate OOB activities.	Ongoing

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4 145	Continued From page 10	4 145	The Activity Director and Activity Coordinators will implement measures to ensure that this deficient practice does not recur, including: • The Activity Director and Coordinators will work with nursing to schedule these "at risk" residents for appropriate OOB activities on a weekly basis. • The Activity Director and Coordinators will add or modify care plans specifically for these residents that are considered "at risk" of isolation related to the inability to express their needs, impaired cognition, issues with mood and/or behaviors. *(continue on addendum page 11A)*	Ongoing 9/05/16 & ongoing
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	4 149	(4-149) Resident's Care Plan for Fall has been revised to include: Resident moved to a room closer to the nurse's station. The Head Nurses/charge nurses will identify other residents having the potential to be affected by this deficient practice including: • Conducting fall risk assessments; based on fall risk assessment scores, care plans will be developed to ensure residents safety. The Head Nurses, DON, Nursing Supervisors will implement measures to ensure that this deficient practice does not recur, including:	8/10/16 8/10/16

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AMENDED POC	125010	C BLDG _____ D WING	07/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 145	Continued From page 11	4 145	• The Activity staff will use the questionnaire from MDS 3.0 section F. Activity Preferences as a guide. In this interview, the resident is asked to answer 16 questions regarding their activity preferences and rate them in the level of importance to the resident. If the resident is unable to answer the questions for the interview based on cognitive deficits, the resident would be considered "at risk of isolation" related to the inability to express their needs, impaired cognition, issues with mood and/or behaviors. The Activity Coordinators and Director will schedule these residents for appropriate OOB activities on a weekly basis and will add or modify care plans, as needed. The Activity Director will monitor corrective actions to ensure effectiveness of these actions, including: • The Activity Director will monitor these residents during monthly QA audits. These residents will be identified on an additional category of the QA process as "at risk for isolation" and checked for monthly participation. • Findings of QA audits and measurements will be shared in staff meetings for actions and recommendations to improve this practice. • Results of QA audits will continue to be reported to the facility's QAPI committee for further actions and recommendations.	9/05/16 & ongoing Ongoing Ongoing Ongoing

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4 149	Continued From page 11 direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: The facility failed to ensure that the resident environment remains free of accident hazards as is possible. And to ensure that each resident receives adequate supervision and assistance devices to prevent avoidable accidents, including: implementing interventions to reduce hazard(s) and risk(s); and monitoring for effectiveness and modifying Interventions when necessary for 2 of 34 residents in the Stage 2 sample. Findings include:	4 149	• In the event of a fall, Head Nurse/Charge Nurse to assess/gather information to determine the cause of the fall, i.e., environmental factor, toileting issue or even underlying medical problems such a pain, body weakness or even confusion. Discuss outcome or any changes of interventions with the staff during shift reports. • Head Nurse to monitor resident's incidences of fall in the unit, discuss and evaluate risk factors with staff, make changes to plan of care as necessary. All incidences of fall to be presented and discussed during IDT meetings. The Fall Committee to reconvene on a weekly basis to discuss further interventions. • The Head Nurse on each unit to monitor and observe staff to ensure interventions are implemented and outcomes to be presented and discussed at QAPI meetings.	Ongoing Ongoing Ongoing

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4 149	Continued From page 12	4 149		

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4 149	Continued From page 13 The cable for the television was hanging dawn from the ceiling and was not secured. It was directly beside the privacy curtain posing as an	4 149	The cable wire was attached to the wall by Maintenance. An assessment was completed to ensure all cabling is secured and unobstructed or does not obstruct other devices and/or equipment to eliminate any potential hazards. Hazard communication protocols will be utilized in communicating and tracking of improper installations. The Head Nurses and/or designee will initiate a 1xwk. review of all of installed television cabling by the cable provider to ensure proper installation has occurred and proper measures are taken when installing new or existing cable to ensure the devices and cabling are properly secured. Monitoring of the cabling will be added to the Nursing Data Collection Tool. Hazard Communication monitoring for cable installation will occur in the Safety Committee Meeting and recommendations will be forwarded to the Quality Assurance Process Improvement committee meeting	7/30/16 8/17/16 Ongoing Ongoing

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4 149	Continued From page 14 accident hazard for someone who might pull the curtain. interview with Unit Manager #2 on 7/26/2016, where the unit manager verified this unsecured cable hanging from the ceiling posed as an accident hazard for residents, staff and visitors in the area.	4 149	The Quality Assurance and Process Improvement committee will review and make recommendations for follow up with the facility Administrator and/or designee. Corrective action will be reported back to the QAPI committee at the next scheduled meeting.	Ongoing
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 observation, review of temperature log for food being served and Interview, the facility failed to ensure residents were provided with food at the proper temperatures. Findings Include: During observation of the food being plated foi residents, no temperatures were seen to be taken of any of the food being served on 7/24/2016 between 11 AM and 11.30 AM. The log to record these temperatures only showed one temperature of 180 consistently for each meal. There was no pre and post serving temperatures being differentiated. No temperatures were recorded for any cold foods being plated on resident trays.	4 159	(4-159) Employees will be retrained to correctly document food temperatures prior to commencement of the tray line and at the conclusion of the tray line for all three meal services on the "*Trayline Temperature Log*". The documentation will be performed by the employee who is responsible for serving the specific item. Food Service Manager (FSM)/temporary assigned FSM will randomly check the food temperature and log to assure proper documentation. To ensure that this practice is being performed consistently, we will assign a staff member to monitor compliance with this requirement. We will also submit documentation to QAPI committee on a quarterly basis.	8/18/16 & ongoing Ongoing Ongoing

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4 159	Continued From page 15 Interview with the dietary manager confirmed that there was no policy for kitchen staff to follow for taking and recording of temperatures for food being platted and served for residents. The **dietary manager** also verified the need to educate the kitchen staff in correctly taking and recording of **temperatures of** food during serving/plating of food.	4 159		
4 161	11-94.1-41(c) Storage and handling of food (c) Hand-washing facilities, Including hot and cold water, soap, and paper towels adjacent to the work areas shall be provided. This Statute is not met as evidenced by: Based on observation and interview the facility failed to ensure **food was served under sanitary conditions** for the residents. Findings include: **1) During observation of the plating/serving** of food on 7/24/2016 at 11 AM -11.30 AM, a food server turned away **from the food, looked at surveyors, stating "It** is hot in here", and then wiped sweat off face with gloved hands. then removed gloves and regloved **without** washing hands. then returned to serving food. One of the kitchen workers who was placing drinks on trays for residents, dropped a on floor and it was left there. Shortly afterwards another kitchen worker went and picked it up **off floor** and placed it back in the refrigerator. Interview with dietary services manager on 7/26/2016, where the manager stated the expectations are that the food server would have washed their hands prior to regloving and that the dropped container of	4 161	(4-161) Food & Nutrition Service (FNS) workers will be required to attend in-service training on safety and sanitation with an emphasis on handwashing and glove use by our Infection Control Coordinator. With regard to items dropped on the floor, such items will be wiped with sanitizer before being placed back into the refrigerator. If we are unable to sanitize the item, it will be discarded. To ensure that this practice is being performed consistently, we will assign a staff member to monitor compliance with this requirement. HNs will utilize the secret shopper approach for hand hygiene audits by asking various nursing and ancillary staff to conduct a minimum of 10 hand hygiene observations per month that occur during mealtimes, patient care, medication passes, and glove changes.	9/01/16 8/01/16 Ongoing 8/22/16

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4 161	Continued From page 16 would have been placed in the trash. 2) On 7/26/2016 at 12:03 PM during a dining observation clinical nursing assistant (CNA#1) and unit manager (UM#2) were passing trays. No hand washing or hand sanitization was observed between passing the trays to a total of five residents. There was also no observation of washing hands or hand sanitization before feeding residents. On 7/27/2016 at 8;21 AM interviewed UM#2 to discussed dining observation and the neglect to wash hands between passing trays and feeding residents, UM#2 acknowledged failure for proper infection control practices, Review of policy and procedure for hand hygiene from ADM which states: "Hand hygiene Is the single most important means of preventing the spread of Infection. Hands should be washed or sanitized: B. Use an alcohol-based hand rub in all other recommended situations, as follows, unless hands are visibly soiled: before and after direct patient contact."	4 161	Infection Control (ICC) and Education Coordinator (ECC) will collaborate to provide inservices on hand hygiene upon hire, at the annual education fair, and just in time training with return demonstrations to assess competency. Employees facility-wide which have patient and food contact will provide their co-workers with a verbal reminder for every missed hand hygiene opportunity to facilitate a culture of patient safety and hand hygiene awareness. Hand hygiene compliance rates will be summarized by HNs on a monthly basis and reported by nursing to the Infection Control Committee on a quarterly basis at which time, the committee will revise action plans as needed.	8/15/16 & ongoing 8/15/16 & ongoing Ongoing
4 162	11-94.1-41(d) Storage and handling of food (d) In the kitchen and food preparation areas, receptacles shall be kept closed by tight-fitting covers, except in the kitchen during hours of food preparation and serving. This Statute is not met as evidenced by; Based on observation and interview the facility failed to ensure outside refuse storage containers were covered with lids. Findings include:	4 162	Leahi FNS will purchase lids for tilting truck if available.	9/01/16

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4 162	Continued From page 17 Observation of the outside refuse storage containers on 7/26/2016 outside of the kitchen area did not have any covering lids in place. One refuse storage container had an attached lid but was not closed. The smaller gray refuse storage container for food scraps had no lid. Interview with the dietary manager on 7/26/2016, confirmed that there was no lid for the gray refuse container for food scraps and that the lid on the larger refuse storage container was not used leaving the refuse storage containers uncovered.	4 162		
4 174	11 -94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on observation, interview, and record review the facility failed to use the results of the assessment to develop, review and revise the resident's comprehensive plan of for 1 of 34 residents in the Stage 2 sample. Finding includes:	4 174	(4-174) The Head Nurse (HN) and Wound Care Nurse will assess residents found to have been affected by this deficient practice, including: • Based on results of Res #91's assessment, a plan of care for was specifically developed to address the care of the actual The HNs, charge nurses, Nursing Supervisors and Wound Care Nurse will identify other residents having the potential to be affected by this deficient practice, including: • Random weekly audits of Treatment Administration Record (TAR) and Weekly Skin Assessment chart audits to ensure care plans specifically addressing actual wounds are developed, reviewed and revised as appropriate. • Random visual skin assessments and chart audits of residents with wounds and ensure documentation of their specific wound care in their care plan.	7/30/16 9/01/16 & ongoing 9/01/16 & ongoing

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4 174	Continued From page '18	4 174	The interim DON, HNs, Nursing Supervisors and Wound Care Nurse will implement measures to ensure that this deficient practice does not recur, including: • A comprehensive review and assessment of all residents who have a wound(s) and ensure that specific care plans addressing the wound care is/are developed. *(continue on page Addendum page 19A)*	9/01/16 & ongoing
4 194	11-94.1-46(k) Pharmaceutical services (k) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. This Statute is not met as evidenced by: Based on observations and interviews,the facility failed to dispose of expired meds as necessary for safe administration process. Findings include:	4 194	(4-194) A 100% review will be conducted by charge nurses of all medication carts, medication refrigerators and treatment carts to ensure that all medications in the carts and refrigerators are within expiration dates. All treatment medications, prn medications, liquid medications, including eye drops, vials and nasal sprays expiration dates will immediately be logged into each unit's calendar when they are delivered by pharmacy. All prn medications and treatment medications that are currently in the medication/treatment cart or medication refrigerator will have expiration dates logged into the unit's calendar. The dayshift charge nurses will be responsible daily to ensure that any medication that is logged as expiring will remove the medication from the cart/refrigerator and reorder supply from pharmacy. *(continue on Addendum Page 19B)*	08/19/16 Ongoing Ongoing

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4 194	Continued From page 19	4 194	• Ongoing random visual skin assessments and chart audits of residents with wounds and ensure documentation of their specific wound care in their care plan. • Re-educate staff regarding assessment, development, ongoing evaluation, and revision of a comprehensive care plan to address wound care, until wound has been healed. The interim DON, HNs, Nursing Supervisors and Wound Care Nurse will monitor corrective actions to ensure effectiveness of these actions, including: • Incorporate random observation in QA observation tool • Findings of QA audits will be shared in staff meetings for actions and recommendations to improve this practice. • Results of QA audits will be reported to the facility's Quality Assurance Performance Improvement (QAPI) Committee for further action and recommendations.	9/01/16 9/01/16 9/01/16 9/01/16 Ongoing

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4 194	Continued From page 19	4 194	Any liquid medication will have a multi-dose vial sticker placed on the medication when medication is ordered with discard date and the date the medication was opened. The discard date will be logged into the unit's calendar by the licensed nurse who opened the medication.	Ongoing
			The night shift charge nurse of each unit will check the medication/treatment cart and medication refrigerator two time (2x) a month auditing for any expired medication.	Ongoing
			The Head Nurse of each unit will perform monthly audits on the medication/treatment carts and medication refrigerators to ensure no expired medications are in carts or refrigerators. The results of the monthly audits will be reported in the quarterly QAPI meetings.	Ongoing
			Expired medication found in medication cart was removed immediately when discovered.	07/28/16

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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 relating to infectious diseases and infectious waste. This Statute is not met as evidenced *by:* Based on observations, staff interviews and policy and procedure, the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and Infection, Findinas include:	4 203	(4-203) The facility will implement a standard of one month for the use of personal reusable hospital supplied items. All current personal reusable hospital supplied items that have been in use for longer than one month will be discarded and replaced accordingly. All personal reusable hospital items will be labeled upon distribution to the resident with the resident name and date of distribution. All personal reusable hospital supplied items will be disinfected after each use and will be disposed of , as needed, due to cracks, stains, soiled or odorous. CNAs will perform daily checks of dates at the beginning of their shifts ad replace any personal reusable hospital items as needed and/or if the item has met the one month deadline for use. HNs will elicit monthly feedback from their CNAs to evaluate whether urinals and other similar patient care equipment is properly labeled and change date is not expired. Recommendations will be forwarded to the QAPI committee. The QAPI committee will review and make recommendations for follow up with the facility Administrator and/or designee. Corrective action will be reported back to the QAPI committee at the next scheduled meeting. Glucometer on Y2 was disinfected using Sani-Cloth Wipes with bleach for a full four minutes.	9/01/16 Ongoing Ongoing Ongoing 7/30/16

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4 203	Continued From page 20 Policy review on 07/28/2016 at 10:00 A.M. obtained from unit manager (UM) (Oahu Region Policies and Procedures Policy No: ORNUR0006) for Accucheck, pages 1 of 29 states on page 5, number 2 - "The manufacturer's guidelines for cleaning of meters and its accessories will be followed", Manufacturers guidelines for Sani-cloth Bleach wipes recommended contact time is 4 minutes,	4 203	All nursing staff will be required to follow the Sani-Cloth Wipes manufacturer's instructions for disinfection for blood borne pathogens, HIV, HBV, HCV will be followed after each use. Annual Accuchek competency training and testing will be conducted in addition to audits to evaluate consistent sanitization. Random audits will be conducted by Head Nurses and Nursing Supervisors to monitor the proper cleaning of the glucometers. The results of these audits will be presented in the quarterly QAPI reporting. (Gloves) - The Wound Care Nurse will re-educate licensed staff on hand hygiene as stated in the Oahu Region Hand Hygiene policy (ORIC002). Mandatory attendance of education sessions will be taken. Power Point on Wound Care Procedures presentations will be accessible online with the nursing Supervisor/HNs to ensure all licensed staff view and sign the attendance sheet. Education department will maintain these records. The HN and/or Wound Care Nurse will conduct random audits of clean dressing technique including sanitizing hands in between glove changes. (Application of topical medicine) – The Wound Care Nurse will re-train licensed nurses on clean wound care procedure, including using cotton tipped applicators for applying topical medicine. Mandatory attendance of education sessions will be taken.	Ongoing Ongoing Ongoing 8/18/16 Online education due by 9/12/16 Ongoing 8/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	126010	A. BUILDING: _____ B. WING	**07/29/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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4 203	Continued From page 21 On 7/29/2016 at 9:34 AM observed the mounted hallway electric fans with dust and lint clinging to the fans' protective wire cover, A white paper towel was swiped over one of the fan wire covering in the presence of housekeeper (I-1K) #1, seeing the brown dirt on the clean paper towel the HK #1 stated "there Is dirt up there". On the same floor in the small dining room in the presence of I-1K #2 a clean paper towel was swiped in the mounted electric fan the towel swipe resulted in brown dirt on the clean towel. HI<#2 stated ' it has dust, I going clean". The Housekeeping Manager (HKM) was interviewed later the same day, when asked how often cleaning of the fans is scheduled the HKM stated, "suppose to be once a month"; when asked if a log is kept to track cleaning, the I-1KM stated no log, only room cleaning is logged but the expectation is the hallway fans outside of the	4 203	A complete assessment of the facility fans will be completed by the Environmental Services Supervisor. All facility fans will be routinely cleaned once a month and will be documented in the "Quality Indicator Survey" daily audit checklist to ensure all fans are tracked throughout the month in meeting their required cleaning at any given time during the month. Findings of the "Quality Indicator Survey" daily audit checklist will be brought to the Infection Control Committee for review, make recommendations and implement changes, as needed, to the schedule of cleaning and/or method of cleaning and forwarded to the Quality Assurance and Process Improvement committee.	Ongoing Ongoing

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AMENDED POC	125010	A. BUILDING: _____ 5. WING _____	07/29/2016

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4 203	Continued From page 22 room are Gleaned at the same time. in an observation on 7/29/26 of fans in 6 of 11 resident rooms on the 5th floor of the Young building, 11 of 15 fans checked were very soiled, caked with dark dust/dirt. In an interview with the UM #3 on 7/29/16, stated that they only have one housekeeper for the unit and so the cleaning of floors, bathrooms, and bedding is the priority. Diking an observation of medication administration on Young 5th floor, it was noted that LN #4 failed to wash hands and touched several items on the medication cart and in the resident room before administering medications to a random resident, LN #4 verified that hand washing/sanitizing should be completed before administering medications to each resident. A review of the facilities "Hand Hygiene" policy under H. B. Use an alcohol-based hand rub in all other recommended situations, as follows, unless hands are visibly soiled: 1. Before and after direct patient contact In an interview with the Infection Control Nurse (ICN) on 7/29/16 at 11:30 AM., the ION validated that hands should be washed between each	4 203	The QAPI committee will review findings for compliance and effectiveness. Recommendations will be forwarded to the Administration for follow up and findings will be reported back to the Quality Assurance and Process Improvement committee. HNs will utilize the secret shopper approach for hand hygiene audits by asking various nursing and ancillary staff to conduct a minimum of 10 hand hygiene observations per month that occur during mealtimes, patient care, medication passes, and glove changes. Infection Control (ICC) and Education Coordinator (ECC) will collaborate to provide inservices on hand hygiene upon hire, at the annual education fair, and just in time training with return demonstrations to assess competency. Employees facility-wide which have patient and food contact will provide their co-workers with a verbal reminder for every missed hand hygiene opportunity to facilitate a culture of patient safety and hand hygiene awareness. Hand hygiene compliance rates will be summarized by HNs on a monthly basis and reported by nursing to the Infection Control Committee on a quarterly basis at which time, the committee will revise action plans as needed.	Ongoing 8/22/16 8/15/16 & on going 8/15/16 & ongoing Ongoing

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AMMENDED POC.	125010	A. BUILDING: 8. WING	07/29/2016

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4 203	Continued From page 23 resident contact. The ION stated that they have a monitoring tool to track compliance which unit managers and supervisors are assigned 10 opportunities for hand sanitizing/washing each month and this is reported to the Infection Control Nurse, 8) In an interview with the Infection Control Nurse (ICN) and Interim DON #2 on 7/29/16 at approximately 11:30 AM when asked about the infection control program, the ICN talked about their monitoring of handwashing and explained that the monthly audits are completed by the head nurse/charge nurse (they observe about 10 employees per unit per month). The information is then shared at the quarterly meeting. Per DON #2, "we need to get tougher, we don't hold the staff accountable, we are too easy and give them reminders". Per ICN the audits show a 98% compliance rate for hand washing based on the data from the audits, When asked how this data is used to improve, the ICN stated that "we haven't had to improve because our data doesn't show we have a problem". When asked about tracking infectious diseases in the facility and how the mapping is done to trend and track. Per ICN "I don't put dots on a map like I did in the past. ICN provides several graphs showing the numbers of residents with infections but there are no maps to show where the infections are showing up in the facility to aid in trending to find patterns. 11-94.1-55(e) Housekeeping	4 203	Licensed nurses will complete surveillance reports for each patient with signs and symptoms of an infection and those admitted on antimicrobials. Licensed nurses will provide labs and chest X-ray results with the surveillance reports. Every patient with and infection will be identified on the Nursing Unit Shift Report by HNs with the following information: Full patient name, bed/room number, infection type and isolation type, vital signs, and O2 saturation to facilitate accurate real time tracking and mapping of infections. IC Nurse will assess compliance with the Surveillance policy by comparing monthly surveillance infection reports with the contracted pharmacy antibiotic reports to check for complete, accurate, and timely submission of data that will enable trending and mapping.	8/01/16 & ongoing 8/01/16 & ongoing
4 218	(e) All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair,	4 218	(See page 25)	

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	Continued From page 24	4 218		
4 218	This Statute is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide a safe, clean, comfortable and homelike environment. Findings include;		Administration reviewed the current practices and protocols for repairs and maintenance to identify areas for improvement and to address and/or eliminate the potential for missing/dislodged ceiling tiles/panels as cited. Administration will modify work order requisitions used to initiate and document the completion of repairs and maintenance in the facility to include "work pending." This will allow the identification of any unfinished work requests and will ensure maintenance staff and managers of the affected areas have evaluated the environment and acknowledge all surfaces remains intact.	8/18/16 9/01/16
4 234	11-94.1-58(a)(3) Emergency preparedness (a) There shall be written policies and procedures to follow in an emergency that shall include provisions for the following: (3) Maintenance of an appropriate emergency preparedness kit for all emergencies or disasters; and This Statute is not met as evidenced by: Based on policy review and interview, the facility failed to have detailed written plans and procedures to *meet* all potential emergencies and disasters, such as fire and severe weather.	4 234	(4-234) The facility has reviewed the Emergency Management Plan and will incorporate the updated emergency water supply plan; potable and non-potable, to each of the binders containing the Emergency Management Plan at every department and/or nursing unit. • The emergency water supply plan will be reviewed annually for appropriateness, updated as needed, in the emergency management committee ensuring an accurate reflection of the maximum resident census and maximum number of employees is accounted for in the plan.	9/01/16 Ongoing

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AMENDED POC	125010	A. BUILDING; _____ S. WING	07/29/2016

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4 234	Continued From page 25 Findings include: Review of policy and procedure in place for water supply during an emergency and/or disaster was not comprehensive in covering the total amount of water stored on the premises for both drinking for residents and staff. The policy did not include the maximum resident census and maximum number of staff that could be present in the facility at any one time. Without this information accurate amount of water for storage could not be calculated. The amount of water that would *be* available for toilet flushing and hygiene purposes for both residents and staff was unable to be accurately calculated with the missing information of the the maximum resident census and maximum number of staff that could be at the facility at any one time. The policy did not include water from the amount of water in hot water tanks could also be utilized during an emergency or how to access the water from hot water tanks *in* the facility during an emergency. interview with maintenance revealed that water from the hot water tanks could be utilized during an emergency.	4 234	• A routine count of the bottled water supply will be assessed during the QIS Environment of Care rounds with findings reported to the regularly scheduled emergency management committee. The facility shall maintain no less than a 3 day supply of water per person; the equivalent to 2 quarts for drinking and 2 quarts for cooking and sanitation per day. The emergency management committee meeting findings will be monitored in the Quality Assurance and Process Improvement committee meeting for review and recommendations. Corrections and/or updates will be provided by the Director of Nursing and Administrator and/or their designee.	Ongoing Ongoing
4 243	1194,1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations, staff interviews, the facility failed to provide a functioning communication system in which the nurses station is equipped to receive resident calls from the residents rooms for 2 residents in the Stage 1 survey. (Residents #149 and #38)	4 243	(4-243) The Maintenance Supervisor conducted in-services related to the operation of the call light system and resetting each unit and distributed instructions to be posted at each unit accessible to staff on the procedures for resetting a unit. Certified Nursing Aides will conduct call-light rounding at the beginning of every shift to ensure all call lights are operating properly. Maintenance will conduct random audits during their daily preventative maintenance rounds to ensure call lights are checked regularly. Work orders will be submitted for the repair or replacement of defective units.	7/30/16 Ongoing

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4 243	Continued From page 26	4 243	Call-light monitoring will be added to the licensed staff unit observation tool and findings to be reported to the safety committee meeting and forwarded to the Quality Assurance and Process Improvement committee.	Ongoing
			Safety committee meeting findings are to be reported in the Quality Assurance and Process Improvement committee for recommendations. Administrator and/or designee will follow up on any outstanding areas of concern and report findings at the next Quality Assurance and Process Improvement committee meeting.	Ongoing