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
	125015	A. BUILDING: _____ B. WING _____	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAHIAWA GENERAL HOSPITAL	128 LEHUA STREET WAHIAWA, HI 96786

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4 000	11-94.1 Initial Comments A state relicensure survey was conducted at the facility from 8/23 - 8/26/2016. At the time of the entrance the resident census was 102.	4 000		
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on observations and interviews the facility failed to provide sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care, for one resident in the Stage 2 sample of 46. Findings include: 1) On 8/24/2016 in the afternoon at 4:50 PM following change of shift observed in the nurses station phones ringing and call lights on in the hallway on the second floor. The Licensed Nurse (LN) #4 on duty was answering the phone calls, there were no other staff visible at the time in the nursing station. At 5:15 PM the LN was observed for a medication pass	4 148	Responsible person(s): Administrator, Director of Nursing (DON), Staffing Resource Coordinator, Nursing Supervisors Additional CNA to assist with answering of call lights and rounding on the floors between 1 1am-7pm hired and scheduled to start. 2.All residents have the potential to be affected by the deficient practice. Additional supportive staff coverage for the nurses' stations on WNRC 1&2 to be provided from 3-7pm Monday through Friday. Evening shift RN Supervisors/Designee will monitor staffing support and report this to the DON on a monthly basis. Results of this monitoring will be reported in the quarterly QAPI meeting for one year and thereafter as determined by the committee.	9/25/2016 Ongoing 10/10/2016 Ongoing

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Rebecca Ann-Fatt — Administrator — 9/21/16

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4 148	Continued From page 1	4 148		

There were no staff at the nursing station during the interview with LN #4 or at anytime during the medication administration observation.

On 8/25/2016 in the afternoon the Nursing Supervisor (NS) #1 for evenings was asked about nursing staff on all shifts. The NS #1 shared on evenings the second floor is staffed with 4 CNAs and 2 LPNs. The second floor has 42 beds. When asked if staff was adequate the NS #1 stated that staffing also depends on acuity but it does get busy and tight at times.

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4 158	11-94.1-40(f) Dietary services (f) The facility shall have a food service plan documented and available for department review that shall include but not be limited to the following: (1) Menus shall be written at least one week in advance; (2) Menus shall provide a sufficient variety of foods served in adequate amounts at each meal, and be adjusted for seasonal changes along with resident preference; (3) A different menu shall be followed for each day of the week. If a cycle menu is used, the cycle shall cover a minimum of four weeks; (4) All menus shall be filed and maintained with any recorded changes for at least three months; and (5) Menus shall be in place for at least three to five days of meal service in case of a natural or external disaster. A plan for meal service in the event of an internal disaster such as interruption of power or water supply shall also be in place and available for departmental review. This Statute is not met as evidenced by: Based on observation and residents and staff interviews, the facility failed to prepare foods that were flavorful, and palatable. Findings include:	4 158	Responsible person(s): EVS Manager, EVS Supervisor, Registered Dietitian Residents will be interviewed again by the Registered Dietitian regarding food preferences.	9/23/2016 9/1/2016 9/13/2016 10/10/2016

A culinary task force conference all with 4 Chefs, Food Services Managers, and the District Manager of Aramark was held for the purpose of making menu adjustments to provide more localized food selections for the Wahiawa General Hospital and Long Term Care patient/ resident menu.

EVS Manager announced this information at the most recent Resident Council Meeting.

All residents who receive meals have the potential to be affected by the deficient practice.

Adjustments will be made to the menu to allow for more variety and culturally sensitive foods. A 4-week menu rotation will be re-implemented.

EVS Manager/Designee will speak with several residents on a monthly basis to evaluate if changes to the menu and food items have improved their satisfaction with the food. Monthly Customer Satisfaction reports from Pinnacle which include Dietary and Food Quality will continue to measure satisfaction in these areas. Administrator will review these reports to see if they indicate improvement in Dietary and Food Quality. Results will continue to be reported in the quarterly QAPI meeting on an ongoing basis. Results of monthly audits with residents will be reported in the quarterly QAPI meeting for one year and thereafter as determined by the committee.

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4 158	Continued From page 3	4 158		

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4 158	Continued From page 4	4 158		

A review of the Resident's Council meeting minutes on the morning of 8/26/16 at approximately 8:00 A.M. revealed the Resident Council discussed the types of foods the residents were tired of eating: cheese, pasta, lasagna. The Resident Council indicated, "Now we have macaroni and cheese," which they weren't very fond of.

A test tray was done for the lunch meal on 8/26/16 since one resident complained of food arriving in the dining room cold. The last tray was served at 11:26 A.M.: The lasagna was 164 degrees; the vegetables were 144 degrees; the fruit was 42 degrees; the milk was 40 degrees; and the poi was 48 degrees. The temperatures held up and was not an issue.

An interview with the Food Service Manager on the afternoon of 8/25/16 at approximately 3:20 P.M. revealed understanding of the residents' dislike for the food. reported that works for a contracted agency who provides the food services to the facility. The Food Service

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4 158	Continued From page 5 Manager stated that in March 2016, the food service agency implemented a company wide change in their food services to a lower fat, lower sodium diet. They also decreased the frequency of menu cycling from 4 weeks to 3 weeks. The Food Service Manager was aware that the residents disliked the change and was working with the facility Administrator to customize their menu to the residents' preferences. The Food Service Manager participated in the Quality Assessment and Assurance program. The Food Service Manager stated also attends resident council meetings, which is how became aware of the residents' dislike for the new menu/cycle. At the time of survey, the Food Service Manager had not yet implemented any changes to the residents' food preferences.	4 158		
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 and staff interview, the facility failed to maintain a sanitary environment during food service.	4 159	Responsible person(s): EVS Manager, EVS Supervisor Food Service huddle held with kitchen staff. Food Service Management directed the cooks and other kitchen staff to eliminate cross contamination by glove changes, hand washing, and avoidance of touching unsanitary surfaces while wearing gloves. All residents who receive meals from the kitchen have the potential to be affected by the deficient practice. Ongoing monitoring of sanitation and the prevention of cross-contamination to be done on a monthly basis Results of the ongoing monitoring will be reported in the quarterly QAPI meeting until such time it is deemed no longer necessary by the committee.	8/25/2016 Ongoing

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4 159	Continued From page 6 Findings include: An observation of the tray line during the dinner meal service on the afternoon of 8/25/16 at approximately 4:15 P.M., found the cook removing the plastic wrap from the food trays on the steam table. With blue gloves on, the cook brought all the trash to the trash can, removed the trash can lid, dumped trash, replaced the trash can lid and returned to the steam table. Without removing gloves and washing hands after touching the trash, the cook gathered various serving utensils and began placing them in their respective food tray. The cook did not remove the soiled gloves, did not sanitize hands, and did not put on clean gloves before proceeding with food service for the dinner meal. An interview of the Food Service Manager on the afternoon of 8/26/16 revealed the Cook was required to remove soiled gloves, wash hands, and put on clean gloves before proceeding with food service.	4 159		
4 185	11-94.1-46(b) Pharmaceutical services (b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and director of nursing that: (1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions	4 185	Responsible person(s): Director of Nursing, RN Supervisors, Long Term Care Coordinators (LTCC), Pharmacy Technician Medication Error Reports were completed for the administration of medication after it expired and the administration of medication after the meal instead of before as ordered. — 8/24/2016 Licensed Nurse will be in-serviced on calling for assistance as needed. — 9/23/2016 Licensed Nurses will be in-serviced regarding the checking of medications and ordering of new ones. — 9/29/2016 9/30/2016	

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4 185	Continued From page 7 and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs; (2) Is reviewed at least every two years and revised as necessary to keep abreast of current developments in overall drug usage; and (3) Has a drug recall procedure that can be readily implemented. This Statute is not met as evidenced by: Based on observation, record review and interviews the facility failed to provide pharmaceutical services, that assure the accurate administering of all drugs to meet the needs for one of 46 residents in the Stage 2 sample. Finding Includes:	4 185	All residents who receive medications have the potential to be affected by the deficient practice. Monthly audits by Pharmacy Technician will continue and reports submitted to Director of Nursing. Nursing will check medications twice a month utilizing a log which will be submitted to the DON. Policy on Medication Administration and Expired Medications reviewed and updated as needed. Results of the bi-monthly audit will be presented at the quarterly QAPI meeting until such time it is deemed no longer necessary by the committee. Results of monthly Pharmacy audit will be reported quarterly at the QAPI meeting as previously.	9/30/2016 Ongoing 9/30/2016

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4 185	Continued From page 8	4 185		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observation, interview and policy review the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection for 2 of 46 residents in the Stage 2 sample. Findings include: 1) On 8/25/2016 at 10:25 AM observed a	4 203	Responsible person(s): Director of Nursing, Wound Care Nurse, RN Supervisors, LTCC's LN#2 was in-serviced on a 1:1 basis by the Director of Nursing on hand washing and changing of gloves. LN#2 signed the Policy and Procedure for Hand Hygiene after DON reviewed it with indicating that understood it. DON observed LN#2 do a dressing change and instructed LN#2 on how to practice proper infection control techniques with preparation and handling of supplies. 9/1/2016 DON will work with LN#2 on a weekly basis until such time can demonstrate an understanding of proper infection control techniques. Staff will be in-serviced on Hand Hygiene at the next staff meeting. 9/29/2016 9/30/2016 All LN's will complete the Healthstream In-service on Infection Control/Hand Hygiene/ PPE. 10/29/2016	

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4 203	Continued From page 9 dressing change by LN #2 During the dressing change LN #2 removed and donned gloves 5 times. Glove change #1 after removing the resident's . No hand sanitizing observed before donning clean glove #2. Glove change #2 after cleansing the . No hand sanitizing observed before donning clean glove #3. Glove change #3, LN #2 put gloves on left hand, leaving right hand ungloved; walked around the resident's bed opened a side drawer with ungloved right hand; walked back to the resident's overbed table; dug right hands into a box of dressings resting on the table; then donned a glove on right hand without hand sanitizing. Glove #3 was removed after wiping No hand sanitizing and glove #4 applied. Glove #4 removed after applying the , then LN #2 walked to the bedroom sink and did a hand lather and rinse in less than 15 seconds and donned Glove #5. Glove #5 removed after secured with tape, then LN #2 used a black marker to write on the . Immediately after the observation LN #2 was interviewed on the hand sanitizing and hand washing policy. LN #2 stated "I know I should hand sanitize between glove changes". When asked if the hand washing lather was for 15 seconds LN #2 stated "I did not do the lather for 15 seconds before rinse". On 8/25/2016 at 10:41 AM Nursing Supervisor (NS) #2 was asked about hand sanitizing between glove changes. NS #2 stated the nurse needs to sanitize between glove changes like when doing a dressing change, they need to sanitize. A review of the facility Policy No. IC-006. Subject: Hand Hygiene. States: "All Personnel	4 203	All residents have the potential to be affected by the deficient practice. DON/Designee will do random observations of different licensed nurses doing dressing changes on a monthly basis. Duration of observations will be determined by DON and Administrator. All WNRC LN's are to complete the Healthstream In-services on Infection Control/Hand Hygiene/PPE developed by the WGH Infection Control Nurse on an annual basis. Results of audit by DON/Designee will be reported in the quarterly QAPI meeting for one year and thereafter as determined by the committee.	

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4 203	Continued From page 10 and Medical Staff should perform hand hygiene (antiseptic handwash or antiseptic hand rub). After, "removing gloves and/or other Personal Protective Equipment (PPE)". Under hand washing, "Vigorously rub hand together for 15 - 20 seconds generating friction on all surfaces of the hands and fingers". Failure to follow the guidelines for effective hand hygiene places residents and staff at risk for the spread of bacteria, germs and infections. An interview of LN #7 on the afternoon of 8/25/16 at approximately 1:45 P.M. revealed understood was required to remove gloves and sanitize hands acknowledged that touched surfaces that weren't clean further indicated should've removed gloves, sanitized hands, and proceeded to don clean gloves before proceeding with removing the dressing.	4 203		

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4 218	11-94.1-55(e) Housekeeping (e) All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair. This Statute is not met as evidenced by: Based on observation and interviews the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Findings include: 1) On 8/23/2016 at 10:45 AM observed in the bathroom a commode seat resting over the bathroom toilet. The metal front frame of the commode was rusted the length of one hand span. The four legs of the commode stand were also marked with rust spots. When asked the RNA #1 stated used the commode and was not sure which department issued the commode 2) On 8/25/2016 at 7:57 AM observed in the rehab department for long term care a dusty ultrasound machine. On the side of the machine was a plastic gel tube lying on its side with no cap. There was a second gel plastic tube with an opened twist cover and an expiration date of 2/2010. The Rehab Manager (RM) agreed the expired gel should not be used and the ultrasound machine should be cleaned. 3) On 8/24/2016 at 11:31 AM in a family interview, when asked if the building was clean the family member stated the window sill and blinds covering the window are dusty and sometimes the resident's sink is dirty. On 8/26/2016 at 7:00 AM a Certified Nurse Aide (CNA) #1 was asked to do a clean paper towel	4 218	Responsible person(s): Rehab Manager/ Designee, Director of Nursing, RN Supervisors/ LTCCs (Long Term Care Coordinators), Food Services Manager, Housekeeping Aides, EVS Manager, EVS Supervisor, Administrator Facility-wide search for faulty commode seat was completed. Commode with rust was removed and discarded. Facility-wide audit will be conducted and inventory taken of all DME in WNRC. Any DME that has rust or is damaged will be discarded. New DME will be purchased as needed. An audit of all DME, once baseline inventory is completed, will be checked on a monthly basis. If results of the audit include any faulty or damaged equipment, this will be reported to the Administrator/Designee immediately. Results of this audit will also be reported at the quarterly QAPI meeting for one year and thereafter as determined by the committee. Ultrasound machine cleaned with disinfectant wipes. Plastic gel tubes removed and discarded. Checked on stock for the individual tubes. New tubes placed on ultrasound machine. Staff in-serviced on new protocol for use of ultrasound machine. Rehab Department will no longer use the larger refillable tubs for ultrasound gel. Therapists are to use non-refillable tubes that will be stocked from the WGH Purchasing Department. Par level of 2 gel tubes will be kept on the ultrasound cart. Therapists are to clean and disinfect the ultrasound equipment after each use. Manager (RSM)/Designee to order more gel tubes if others are empty. Policy and Procedure to be developed regarding new protocol. RSM/Designee to perform weekly checks of the equipment to ensure it is in proper working	8/25/2016 10/10/2016 8/25/2016 8/25/2016 Ongoing 10/10/2016

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4 218	Continued From page 12 swipe of the resident's window sill and blinds. The swiped paper towel revealed brown dust residuals and dirt. The CNA #1 agreed that the blinds and window sill were dirty. At 7:04 AM on the same day the Housekeeper (HK) #1 was asked to do a clean paper towel swipe of the oscillating fan mounted on the corner wall facing . The HK #1 turned off the oscillating fan and did a clean paper swipe over the fan's protective metal casing. The swipe took off some of the brown dust from the fan's protective metal casing. Both the Housekeeper and CNA agreed that the window sill, blinds, and fan were dirty. Observation made on 08/26/2016 at 1:00 PM with Maintenance Supervisor and Housekeeping supervisors. Both supervisors acknowledged that proper cleaning and maintenance depends on time restraints, resources, and prompt reporting from staff.	4 218	condition and clean, and that Rehab supplies are not expired. Results will be reported in the quarterly QAPI meeting until such time the committee deems it is no longer necessary. Environmental Services staff were huddled and EVS Manager and Supervisor in-serviced Housekeeping aides to clean resident blinds, floors, and fans on a rotational basis to decrease the build-up of dust. Window sill, blinds, sink, and oscillating fan were cleaned. floor was stripped and waxed. Inventory of all WNRC rooms with oscillating fans to be completed. WNRC resident rooms were placed on a rotational project timeline for deep cleaning. Room cleaned. Pest Control Service serviced room. Pest Control Service completed all of WNRC. New Pest slip will be sent to Housekeeping services. Environmental Services staff were huddled and EVS Manager and Supervisor in-serviced Housekeeping Aides to clean resident blinds, floors, and sinks on a rotational basis for decreasing the build-up of dust. Ongoing monitoring via audit of sanitation and cleanliness will be done on a monthly basis. Results of this monitoring will be reported in the quarterly QAPI meeting for one year and thereafter as determined by the committee. All residents have the potential to be affected by the deficient practice. Responsible Person(s): EVS Manager, EVS Supervisor, Facilities Walk-in freezer was inspected by the Wahiawa General Hospital Facilities Department to check for external structural concerns.	8/25/2016 8/27/2016 9/10/2016 10/10/2016 8/26/2016 Ongoing 8/27/2016 8/9/2016 9/13/2016 9/22/2016 8/25/2016 9/21/2016
4 243	11-94.1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition.	4 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125015	A. BUILDING: _____ B. WING _____	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAHIAWA GENERAL HOSPITAL	128 LEHUA STREET WAHIAWA, HI 96786

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4 243	Continued From page 13 This Statute is not met as evidenced by: Based on observations and facility staff interviews, the facility failed to maintain a safe, functional, sanitary and comfortable environment for residents, staff and the public. Findings include: An initial tour of the kitchen on the morning of 8/23/16 at approximately 8:15 A.M. found the walk in freezer in disrepair. There were 2 large pieces (approximately 8-9 inches in the shape of circles) of ice frozen onto the ceiling of the freezer above the 2 freezer fans. In between the 2 freezer fans there was a large piece (approximately 10-11 inches) of fiberglass-looking material hanging down from the ceiling. An interview with the Food Production Manager on the morning of 8/23/16 at approximately 8:18 A.M. revealed the 2 pieces of ice on the freezer ceiling were from the freezer going into defrost mode during the day. The Food Production Manager stated that the piece of material hanging from the ceiling above the fans was part of the freezer's insulation coming apart from the freezer. stated that they have not recently had maintenance services on the freezer. The Food Production Manager further stated the freezer was "really old". A follow up visit to the kitchen on the afternoon of 8/25/16 at approximately 3:20 P.M. found the same 2 pieces of ice frozen on the freezer ceiling above the 2 freezer fans. The piece of insulation was also hanging between the 2 ceiling fans. The surveyor and a different manager with the title, Food Service Manager, stood in the doorway of the walk in freezer and were talking about the maintenance and repair of it when small gray	4 243	Food Service Manager to discuss options with CEO for internal structural concerns. All residents have the potential to be affected by the deficient practice as all WNRC/WGH frozen food is stored in this freezer. Based on discussions with CEO, freezer will either be repaired or replaced. If not replaced, freezer will be placed on a regularly scheduled preventive maintenance program with frequency of audits decided between EVS Manager and Facilities Manager. Ongoing monitoring of the freezer structure for internal changes will be done on a weekly basis and results will be reported in the quarterly QAPI meeting until such time it is deemed no longer necessary by the committee.	

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4 243	Continued From page 14 fragments were dropping onto the surveyor's arm. The Food Service Manager acknowledged the gray fragments and reported it was "cement" from the freezer structure which had broken down from condensation and was crumbling. Observation of the doorway to the walk in freezer found the cement was breaking down around various parts of the doorway. On the upper left hand side of the doorway the cement had significantly broken down to reveal chicken wire, which was deep (approximately 1.5 - 2 inches) under the cement. An interview of the Food Service Manager on the afternoon of 8/25/16 revealed the facility had done maintenance on the freezer's components (compressor, fans, mechanical parts, etc.) but had not had any maintenance on the structure of the freezer in "many years". The Food Service Manager stated the freezer was very old and acknowledged the need for maintenance/servicing. Since maintenance had not been done in a long time, the Food Service Manager was unable to provide any maintenance logs for the walk in freezer.	4 243		
4 281	11-94.1-65(e)(8) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (8) Each resident shall be provided with: (A) A separate bed of proper size and height for the convenience of the resident and that permits an individual in a wheelchair to get in and out of bed unassisted; (B) A comfortable mattress with impermeable mattress cover, and a pillow with an impermeable cover;	4 281	Responsible person(s): Certified Nursing Assistants, Housekeepers, Long Term Care Coordinators, Unit Clerks Pillow was removed from room, discarded and replaced. 8/23/2016 A facility wide audit of all linens will be completed. 10/10/2016 All WNRC residents have the potential to be affected by the deficient practice because all residents are issued linens when admitted. Checking of bed linens will be added to the admissions checklist currently completed by the RN in charge at the time of admission.	

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4 281	Continued From page 15 (C) Sufficient clean bed linen and blankets to meet the resident's needs; (D) Appropriate furniture, cabinets, and closets, accessible to and meeting individual resident's needs. Locked containers shall be available upon resident's request; and (E) An effective signal call system at the resident's bedside. This Statute is not met as evidenced by: Based on observations and interviews the facility failed to provide clean bed and bath linens in good condition. Findings include:	4 281	This item will also be added to the daily stand up agenda under "Admissions" to ensure linens are checked prior to admission. In-service with staff regarding the checking of linens. A monthly audit will be done to monitor bed linens and results of this audit will be presented at the quarterly QAPI meeting for one year and thereafter as determined by the committee.	9/29/2016 9/30/2016