

Hawaii Dept. of Health, Office of Health Care Assurance

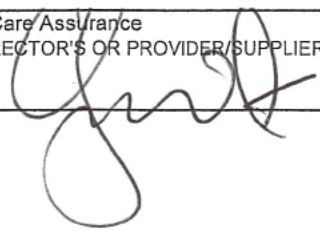
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  <b>AMENDED POC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/22/2016</b>
--	---	--	---

RECEIVED  
2016 SEP 12 P 2:37

NAME OF PROVIDER OR SUPPLIER  <b>KAHUKU MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>56-117 PUALALEA STREET KAHUKU, HI 96731</b>
--	---

(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 re-licensing survey was conducted at Kahuku Medical Center from 7/19/16 through 7/22/16. At the time of entrance the census was 5.	4 000		
4 128	11-94.1-28(b) Resident accounts  (b) Upon request of each resident or legal guardian or surrogate, articles kept for safekeeping shall be released.  This Statute is not met as evidenced by: Based on resident and social worker interviews along with record review of policy and procedures, the facility failed to ensure that residents who have authorized the facility to manage any personal funds have ready and reasonable access to those funds. Requests for less than \$50.00 should be honored within the same day.  Finding include:	4 128	<b>4 128</b> As of 7/22/2016, Kahuku Medical Center has modified our KMC Resident Trust Fund Policy to extend cash availability to weekends and/or holidays. A portion of the policy reads: Upon resident's request to withdraw funds, resident will sign Resident Withdrawal from Resident Trust Fund form (Appendix B). Social Services will assist in obtaining resident's check or cash of which a third party/witness will observe issuance and also sign form.  A. During the weekend (Saturday, Sunday), and days (i.e. holiday, vacation, sick call, etc.) when social services staff are unavailable to assist resident with withdrawing of funds, the charge nurse will assist resident with this process. Resident to complete the resident withdrawal with charge nurse form. B. During the unusual occurrences when social services are not available, the charge nurse will obtain funds from the chief financial officer (CFO). If CFO is not available, charge nurse will follow the weekend process. C. During the weekend (i.e. holiday vacation, sick call, etc.), funds will be available through the dietary department. The process will include resident's completion of withdrawal form and charge nurse to obtain, and provide, funds to resident.	<u>09-05-16</u>

Office of Health Care Assurance  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

CFO

(X6) DATE

9/21/16



Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  125030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/22/2016
---	--	---	--

NAME OF PROVIDER OR SUPPLIER  KAHUKU MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 56-117 PUALALEA STREET KAHUKU, HI 96731
---	---

(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
4 172	Continued From page 2  education regarding the benefits and potential side effects of influenza immunization.  Findings Include:	4 172	<b>4 172 (continued)</b> the beginning of the nationally determined flu season, ensuring that all residents are current with their age-appropriate immunizations or vaccinations including but limited to pneumococcal and annual influenza vaccines and any necessary immunizations. Residents will be given a seasonal flu vaccine (subject to availability) unless administration of the vaccine is contraindicated, the resident or the resident's legal representative refuses, or the resident's attending physician orders otherwise. A PCV 13 (Pneumovax) vaccine will be given if PPSV23 (Pneumovax) has been administered over one year ago. If no previous PPSV23 vaccine has been given within the last five years, the PCV13 vaccine will be given now with a follow-up PPSV23 vaccine given no earlier than 8 weeks later. A Td vaccine booster will be administered every 10 years. If there is not documented history or reliable self-report of having received a Td booster within the last 10 years, one will be administered upon admission or during healthcare stay. A CDC Immunization Information Sheet "What You Need to Know", which includes the benefits and risks will be provided to the resident at the time the vaccine is offered. Residents or their legal representative will be required to indicate verbally their	
4 173	11-94.1-43(a) Interdisciplinary care process  (a) A comprehensive assessment shall be completed for each resident by an interdisciplinary team at least annually and updated as appropriate, based on the resident's condition.  This Statute is not met as evidenced by: Based on staff interview and record review the facility failed to review and revise 1 of 5 resident's comprehensive plan of care.  Findings include:	4 173		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  125030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/22/2016
---	--	---	--

NAME OF PROVIDER OR SUPPLIER  KAHUKU MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 56-117 PUALALEA STREET KAHUKU, HI 96731
---	---

(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
4 173	Continued From page 3	4 173	<p><b>4 172 (continued)</b> decision to accept or decline the vaccinations. nursing staff will document administration, resident refusal, or physician's order to withhold a vaccine in the resident's medical record. Nursing staff who administered the vaccine will enter the information in the <i>Vaccine Administration Record</i> of the resident.</p>	
4 203	<p>11-94.1-53(a) Infection control</p> <p>(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.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record reviews the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p>	4 203	<p><b>4 173</b> Kahuku Medical Center's interdisciplinary team meets together on the first Tuesday of each month to review and update the <i>Residents Plans of Care</i>. A comprehensive assessment for each resident is completed and updated at each of these meetings. KMC's clinical IT coordinator is currently working with our EMR vendor to rectify the automatic deletion of said <i>Care Plans</i>. A resolution is anticipated by September 30, 2016.</p>	09-05-16

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  <b>AMENDED POC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/22/2016</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KAHUKU MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>56-117 PUALALEA STREET KAHUKU, HI 96731</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 203	<p>Continued From page 4</p> <p>Findings Include:</p> <p>In an interview with the LN in charge of Infection Prevention, Clinical Quality and Risk Management on 7/21/16, when asked about the facility infection control program, she stated "I just started in September on infection control, no one was in the position for 2 years before me" She stated she attended APIC in September and is now working on implementing some programs. One infection control practice she stated they were monitoring was handwashing. She stated that they had 86% compliance but our goal was 95%. She stated that she "trained all permanent front line staff to do hand hygiene observations. They would turn in 10 per week. The person is expected to do on the spot coaching "in the moment"". She further went on to say, "I tried to implement a reporting systems for those who are consistently reported to have poor hand hygiene. Holding people accountable is a problem". She further stated that "there is no way to evaluate if they are training, but compliance rates have gone up. Now everyone is aware of how hand hygiene is observed. I feel there is more compliance".</p> <p>When asked how the facility demonstrates that it uses records of incidents to improve its infection control processes and outcomes by taking corrective action she stated "there is an incident reporting system, as far as using it for reporting it hasn't been used to report breaches in IC. I handle them in the moment".</p> <p>When asked if the facility has processes and procedures to identify and prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their</p>	4 203	<p><b>4 203</b></p> <p>KMC's Infection Preventionist (IP) will continue to perform regular surveillance of the residents for any infection control issues to prevent and control infections in the facility and maintain a record of incidents and corrective actions related to infections. Through this surveillance the IP will decide what procedures are needed to take place, such as if isolation should be applied to a particular resident. Within 30 days (September 30, 2016), the IP will work with the employee health coordinator in creating a policy that prohibits employees with communicable diseases or infected skin lesions from direct contact with residents or their food. The IP will continue with her hand hygiene monitoring program and will work with the chief nursing officer in instituting a reporting system for when there is non-compliance with hand hygiene. Within 60 days (October 31, 2016) the IP will create competencies for all levels of disinfection for all staff that do any type of disinfection</p>	<u>09-05-16</u>

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  <b>AMENDED POC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/22/2016</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  
**KAHUKU MEDICAL CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**56-117 PUALALEA STREET  
KAHUKU, HI 96731**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 203	Continued From page 5  food, if direct contact will transmit the disease, she replied "that process is under construction. There was a process but we have a new employee health director. We are talking about it". Stated there is no policy but "it is a priority to create that process".  When asked about disinfecting equipment she stated that they use EO water for disinfecting anything from equipment from room to shower chair - kills Cdiff/MRSA - basic high ph level water solution". When asked about the wait time to leave solution on equipment she stated "I'm not sure, the purple top needs to stay on until it dries". She was unsure of the wait time for the solution to remain on the equipment. She stated that there is no training for staff on disinfecting patient equipment. She stated they have no competencies at this time "but it's going to". She reiterated that they do need to develop policies and procedures along with training.	4 203		
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.  This Statute is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure patient care equipment was kept in safe operating condition for five out of five residents. Findings Include:	4 243	<b>4 243</b> Per product manual instructions, all patient bed scales have been checked for accuracy with a calibrated 50 lb. weight. Each patient bed has also had its semiannual preventative maintenance performed, between 8/6/2016 - 8/16/2016. A contract to ensure that preventative maintenance will be performed semiannually was entered into with Stryker Medical, as of 8/15/2016. Patients weights will be taken as ordered by the attending physician, hospitalist. Any discrepancy of greater than 2.5 Kilograms will be brought to the attention of Kahuku Medical Center's dietician, the resident's primary care provider and the hospitalist. The discrepancy and any changes to the changes to the resident's plan of care will be reviewed and brought to the interdisciplinary team at utilization review, which is held every Wednesday at 10:00 AM.  A contract to ensure that preventative maintenance will be performed semiannually was entered into with Stryker Medical, as of 8/15/2016.	<b>08-31-16</b>

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <b>AMENDED POC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/22/2016</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KAHUKU MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>56-117 PUALALEA STREET KAHUKU, HI 96731</b>
--	---

(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
4 243	Continued From page 6	4 243		