Hawaii [Dept. of Health, Offic	e of Health C Assuranc			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: AMENDED POO		(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	TRACTA PROGRAMMO, PROVINCE	125031	B. WING	DECEIVE	12/09/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
KOHALA	HOSPITAL	54-383 HC KAPAAU,	SPITAL ROA HI 96755	2017 FEB - 2 P 12	2: 22
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BEC COMPLETE
4 000	11-94.1 Initial Com	ments	4 000	4 130 11-94. 1-29(a)	
	A licensure survey through 12/9/16. T	was conducted from 12/6/16 he census was 21.		Resident abuse, neglect, and misappropriation	
4 130	misappropriation (a) The facility sha written policies and mistreatment, residents and misaproperty.	dent abuse, neglect, and Il develop and implement procedures that prohibit neglect, and abuse of ppropriation of resident met as evidenced by:	4 130	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Re-inservice to all clinical staff regarding "SPOT" program to prevent abuse with emphasis on stopping the abuse immediately, protect the resident, ousting or removing the alleged perpetrator immediately away from the residents (and all other residents) including alleged abuse, and tell or report alleged/actual abuse directly	
	Based on review of procedures, record members, the facility policy and procedure abuse and protecting investigation. Finding includes: Cross Reference to	the facility's policy and review and interview with staff ty failed to implement their res for reporting allegations of ag the resident during the \$11-94.1-29(b). On 12/7/16 illity provided a copy of the		(face to face or via telephone) to immediate supervisor &/or Chief Nurse Executive. Perpetrator of abuse will be removed off the floor and from resident care pending investigation. With the purpose of protecting all other residents from potential future abuse. Also, Administrator, State Agency, and Adult Protective Services will receive initial report of the alleged	
	facility's policy and meglect (Rights and Individual and Patie) The policy entitled "the Individual" inclumandatory reporting hours and to immediate the patient by stopp the abuser.	Rights and Responsibilities of des in the policy requiring to the State Agency within 24 diately take steps to protect ing the abuse and removing not ensure the Charge Nurse		abuse no later than 24 hours of the event from the Chief Nurse Executive. The Chief Nurse Executive will provide the results of the investigation within five working days of the reported incident to State Agency and Adult Protective Services. Administrator will assure that final report is done within five working days and audit to assure that final report was sent to State Agency and Adult Protective Services. Re-inservice	

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

LITLE Administrator

(X6) DATE 1/30/17

STATE FORM

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AMENDED POO			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
Hawaii Dept. of Health, Offic	e of Health Ca. Issuranc		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KOHALA HOSPITAL

54-383 HOSPITAL ROAD

NOTIALA	K	APAAU, HI 96755		
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4 130 4 131	Continued From page 1 on duty was able to identify the report as ar allegation of abuse; therefore, the CN did not implement the policy and procedures for retember immediately and protecting the residents. 11-94.1-29(b) Resident abuse, neglect, and misappropriation (b) All alleged violations involving mistreating neglect, or abuse, including injuries of unknown source or origin, and alleged misappropriation of resident property shall reported immediately to the administrator the facility, and to other officials in accordance with state law through established process.	ment, nown be or of nice	conducted by Registered Nurse Educator by 1/3/2017. Inservice of all Department Managers on 12/13/2016 by Chief Nurse Executive. Re-inservice all supporting departments on "SPOT" program before 1/3/2017 by Registered Nurse Educator. Charge Nurse was inservice on "SPOT" program and identifying any allegations of abuse and implement the policy and procedures for reporting immediately and protecting the residents before 1/3/2017 by Registered Nurse Educator.	
	This Statute is not met as evidenced by: Based on a review of an event report and interview with staff member, the facility failed ensure alleged violation involving abuse was reported to the Administrator and other offic (including the State Agency and adult prote services) no later than 24 hours of the ever facility also failed to ensure the results of all investigations are provided to the Administration and State Agency within 5 (five) working dathe incident. The facility did not prevent fur potential abuse while the investigation is in process. Findings include:	is cials ctive nt. The I ator ys of	How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. Re-inservice to all clinical staff regarding "SPOT" program to prevent abuse with emphasis on stopping the abuse immediately, protect the resident, ousting or removing the alleged perpetrator immediately away from the residents (and all other residents) including alleged abuse, and tell or report alleged/actual abuse directly (face to face or via telephone) to immediate supervisor &/or Chief Nurse Executive. Perpetrator of abuse will be removed off the floor and from resident care pending investigation. With the purpose of protecting all other residents from potential future abuse. Also, Administrator, State Agency, and Adult Protective Services will	

Hawaii Dept. of Health, Office	e of Health Ca. Assuranc		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

54-383 HOSPITAL ROAD

KOHALA	HOSPIIAL	54-383 HOSPITAL ROAD KAPAAU, HI 96755				
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4 131	Continued From page 2	4 131	receive initial report of the alleged abuse no later than 24 hours of the event from the Chief Nurse Executive. The Chief Nurse Executive will provide the results of the investigation within five working days of the reported incident to State Agency and Adult Protective Services. Administrator will assure that final report is done within five working days and audit to assure that final report was sent to State Agency and Adult Protective Services. Re-inservice conducted by Registered Nurse Educator by 1/3/2017. Inservice of all Department Managers on 1by 2/13/2016 Chief Nurse Executive. Re-inservice all supporting departments on "SPOT" program before 1/3/2017 by Registered Nurse Educator. Charge Nurse was inservice on "SPOT" program and identifying any allegations of abuse and implement the policy and procedures for reporting immediately and protecting the residents before 1/3/2017 by Registered Nurse Educator. Inservice for all Residents at January 2017 Resident Council Meeting by Chief Nurse Executive by 1/31/2017.			
			What measures will be put into practice or what systemic changes you will make to ensure the deficient practice does not recur. Procedure for Kohala Hospital Administrator and /or designee to			
			conduct investigation and provide the results to State Agencies and			

Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 4MENDED POC. 125031 STREET ADDRESS, CITY, STATE, ZIP CODE 54-383 HOSPITAL ROAD KAPAAU, HI 96755 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 4 131 Continued From page 3 Continued From page 4 Continued From page 5 Continued From page 5 Continued From page 7 Continued From From Page 7 Continued From Page 7 Co	Hawaii L	Dept. of Health, Office	e of Health Ca. Assuranc				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 54-383 HOSPITAL ROAD KAPAAU, HI 96755 (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG COntinued From page 3 4 131 Continued From page 3 Adult Protective Services within 5 working days of the incident, Daily operation clinical meeting will continue to include question of any actual or alleged abuse. All abuse will be reported to Administrator, State Agency, and Adult Protective Services and final report will be provided within five working days. by 12/31/2016. How the corrective action will be monitored to ensure the deficient practice will not recur. Bi-annually inservice on "SPOT" program and policy/procedure in preventing and stopping resident				1			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 54-383 HOSPITAL ROAD KAPAAU, HI 96755 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 4 131 Continued From page 3 4 131 Adult Protective Services within 5 working days of the incident. Daily operation clinical meeting will continue to include question of any actual or alleged abuse. All abuse will be reported to Administrator, State Agency, and Adult Protective Services and final report will be provided within five working days. by 12/31/2016. How the corrective action will be monitored to ensure the deficient practice will not recur. Bi-annually inservice on "SPOT" program and policy/procedure in preventing and stopping resident	, a	AMENDED POC					
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PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 4 131 Continued From page 3 4 131 Continued From page 3 4 131 Adult Protective Services within 5 working days of the incident. Daily operation clinical meeting will continue to include question of any actual or alleged abuse. All abuse will be reported to Administrator, State Agency, and Adult Protective Services and final report will be provided within five working days. by 12/31/2016. How the corrective action will be monitored to ensure the deficient practice will not recur. Bi-annually inservice on "SPOT" program and policy/procedure in preventing and stopping resident	NOTIALA	THOUTTAL	KAPAAU,	HI 96755			
working days of the incident. Daily operation clinical meeting will continue to include question of any actual or alleged abuse. All abuse will be reported to Administrator, State Agency, and Adult Protective Services and final report will be provided within five working days. by 12/31/2016. How the corrective action will be monitored to ensure the deficient practice will not recur. Bi-annually inservice on "SPOT" program and policy/procedure in preventing and stopping resident	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
Bi-annual education to resident council regarding abuse prevention and reporting will be started in January 2017. Orientation - education of all New Employees to include "SPOT" program and policy/procedure in preventing and stopping resident abuse starting in January 2017. Date(s) when corrective action will be completed;		11-94.1-36(b) Admit (b) These policies s (1) The facility shal admission of any instate civil rights and regulations. Should provide care and setheir age, i.e., infant disability, the facility their policies and pr (2) The facility residents whose negulations which it is affiliated by the second control of the second control o	ssion, transfer, and discharge shall ensure that: Il not discriminate against dividual as per all federal and anti-discrimination the facility not be able to ervices to individuals based on ts and youth, or specific will need to indicate so in occedures and by-laws; shall accept only those eds can be met by the facility operation with community providers of care with ited or has contracts;		Adult Protective Services within working days of the incident. Da operation clinical meeting will continue to include question of a actual or alleged abuse. All abuse will be reported to Administrator State Agency, and Adult Protective Services and final report will be provided within five working date by 12/31/2016. How the corrective action will monitored to ensure the deficion practice will not recur. Bi-annually inservice on "SPOT program and policy/procedure in preventing and stopping resident abuse. Bi-annual education to resident council regarding abuse prevent and reporting will be started in January 2017. Orientation - education of all Ne Employees to include "SPOT" program and policy/procedure in preventing and stopping residen abuse starting in January 2017. Date(s) when corrective action will be completed; By 1/31/2017 and ongoing. 4 138 11-94.1-36(b) Admission, transfer, and discharge What corrective action will accomplished for those resident found to have been affected the deficient practice. Chief Nurse Executive and	any sse r, ive sys. be ent t ion ew n t d be lents by	1/31/2017

Hawaii [Dept. of Health, Offic	e of Health Ca			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		SURVEY
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4 138	or mental condition level of service adequately provider shall be transferred of providing an app (4) Except in the resident or the resident or the resident or surrogate and be informed in advantage to and (5) The facility' equipped, and main resident's healt residents, personner This Statute is not Based on resident i policy review the factory were given notice b room mate change,	necessitating a different or care that cannot be d by the facility, the residents promptly to a facility capable ropriate level of care; ne case of an emergency, the dent's legal guardian, family, d the attending physician shall ance of the transfer or other facility; and s buildings are constructed, stained to protect the h, and assure the safety of el, and visitors. The tas evidenced by: The transfer or other facility interview, and cility failed to ensure residents efore a room change and a including the reason for the sampled residents who were	4 138	1/3/2017 to provide notice to residents prior to room change room mate change and to increason for change. Nurse to document in the resident's change. How will you identify other residents having potential to affected by the same deficie practice and what corrective action will be taken. Inservice by Registered Nurse Educator to all clinical staff to provide notice to residents &/Power of Attorney prior to room change and room mate change to include reason for change. Nurse to document in the resident of this notification and explanation of the change by 1/3/2017. What measures will be put in practice or what systemic changes you will make to ensure the deficient practice does not recur. During daily operation meeting with the Clinical Team; Chief Nurse Executive or designated will monitor notification to residents for room & room mate changes and reason why starting January 2017 and ongoing for 3 months. How the corrective action will monitored to ensure the deficient practice will not recur.	ge and clude nart of cion of o be nt e comme and dent's nato sure ot general staff te ng next	
				Assistant Nurse Manager will check charting when there is a		

Hawaii [Dept. of Health, Office	e of Health Ca Assuranc			FORM	APPROVED
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4 138	Continued From pa	ge 5	4 138	room or room mate change start January 2017 for the next 3 months.	ing	
				Date(s) when corrective action will be completed By 1/3/2017 and ongoing.	l	1/3/2017
				4 159 11-94.1-41(a) Stora and handling of food	age	
				What corrective action will be accomplished for those reside found to have been affected by the deficient way to	ents	
				the deficient practice. Registered Nurse Educator inserviced staff member on proper hand sanitizing - alcohol based		
e management de projection de				hand washing with soap and we before and after patient contact between tasks and procedures, between feeding different resid	and in	
TOTOLOGICAL PROMINENCIA PROPERTY AND				and when contaminating hands touching other surfaces or body parts i.e. face, hair etc. by 12/9/2016.	by	
				How will you identify other residents having potential to laffected by the same deficient practice and what corrective		a de la desta de la constante
4 159	11-94.1-41(a) Stora	ge and handling of food	4 159	action will be taken. Registered Nurse Educator inservice all clinical staff regard	ding	
Auginistrates escalada anticipanda.		procured, stored, prepared, yed under sanitary conditions.		prevention of cross contaminati during feeding residents. To sanitize with alcohol based or h	on and	
		e food items shall be stored ventilated room not subject		wash with soap and water befor and after patient contact and in		

above the floor in a ventilated room not subject

to seepage or wastewater backflow, or

contamination by condensation, leakages,

rodents, or vermin; and

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between feeding different residents

and when contaminating hands by touching other surfaces or body parts i.e. face, hair etc. by 1/3/2017.

PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 4 159 Continued From page 6 (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. What measures will be put into practice or what systemic changes you will make to ensure the deficient practice does not recur. Portable hand sanitizers will be	Hawaii De	<u>Dept. of Health, Offic</u>	e of Health Ca. Assuranc		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE KOHALA HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE KOHALA HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE KOHALA HOSPITAL KAPAAU, HI 96755 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE DEFICIENCY) 4 159 Continued From page 6 4 159 What measures will be put into practice or what systemic changes you will make to ensure the deficient practice does not recur. Portable hand sanitizers will be	STATEMENT AND PLAN O	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	1			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 54-383 HOSPITAL ROAD KAPAAU, HI 96755 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 4 159 Continued From page 6 (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. What measures will be put into practice or what systemic changes you will make to ensure the deficient practice does not recur. Portable hand sanitizers will be		AMENDED FOR	125031	B. WING		12/0	9/2016
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 4 159 Continued From page 6 (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) What measures will be put into practice or what systemic changes you will make to ensure the deficient practice does not recur. Portable hand sanitizers will be	AME OF PR	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	1	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 4 159 Continued From page 6 (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. What measures will be put into practice or what systemic changes you will make to ensure the deficient practice does not recur. Portable hand sanitizers will be	KOHALA I	HOSPITAL			AD		
(2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. What measures will be put into practice or what systemic changes you will make to ensure the deficient practice does not recur. Portable hand sanitizers will be	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
Based on observations, policy review, and interviews the facility failed to serve food in accordance with professional standards for food service safety. Finding includes: How the corrective action will be monitored to ensure the deficient practice will not recur. Charge nurse, assistant nurse managers and/or assigned staff will do random checks in dining room to assure cross contamination is not done by staff during feeding and serving food starting 1/3/2017 and ongoing for 3 months Date(s) when corrective action will be completed 1/2/2017 and accordance with them prior to feeding a resident and when hands are contaminated by touching surfaces or body parts by 1/6/2017. How the corrective action will be monitored to ensure the deficient practice will not recur. Charge nurse, assistant nurse managers and/or assigned staff will do random checks in dining room to assure cross contamination is not done by staff during feeding and serving food starting 1/3/2017 and ongoing for 3 months Date(s) when corrective action will be completed		(2) Perishable proper temperature and prevent sport and prevent sport and prevent sport and prevent interviews the facility accordance with preservice safety.	foods shall be stored at the es to conserve nutritive value oilage. met as evidenced by: ions, policy review, and ty failed to serve food in	4 159	practice or what systemic changes you will make to ensu the deficient practice does not recur. Portable hand sanitizers will be placed on afood carts for each clinical staff to take with them to feeding a resident and when hands are contaminated by touching surfaces or body parts 1/6/2017. How the corrective action will monitored to ensure the deficient practice will not recur. Charge nurse, assistant nurse managers and/or assigned staff of do random checks in dining room to assure cross contamination is done by staff during feeding and serving food starting 1/3/2017 and ongoing for 3 months Date(s) when corrective action will be completed 1/3/2017 and ongoing for next 3	be ent will m not i	1/3/2017

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4 159	Continued From pa	ge 7	4 159			
				4 173 11-94.1-43(a)		
				Interdisciplinary care process		
		ity policy titled, "Hand		What corrective action will be accomplished for those reside found to have been affected to the deficient practice. RAI Coordinator completed an submitted Resident comprehensive MDS Admission.	ents by	TO THE TO THE
	hand washing with antisepsis with alco	 Hands must be cared for by soap and water or by hand hol-based handrubs, if hands Before and after patient 		assessment by 1/6/2017.		
	the morning of 12/9 A.M. revealed the s	Director Of Nursing, DON, on /16 at approximately 11:00 taff member should have er hands before feeding the		How will you identify other residents having potential to affected by the same deficient practice and what corrective action will be taken. RAI Coordinator reviewed all residents who were admitted/readmitted in the last 6 months at a second details.	t 	
4 173	(a) A comprehensi completed for each interdisciplinary tea		4 173	assured that all comprehensive admission assessment were dor and submitted by 1/6/2017. What measures will be put in practice or what systemic changes you will make to ensuthe deficient practice does not receive.	to ure	

sample.

assessment for 1

This Statute is not met as evidenced by:

residents of the 21 residents in the Stage 2

Based on record review and interview with staff

member, the facility failed to accurately code an

RAI Coordinator attended re-

inservice on 12/13/2016 with

another CAH RAI Coordinator to

organizational skills to accomplish

comprehensive admission MDS in a timely manner prior to due date.

learn scheduling techniques and

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of 12 sampled

Hawaii [Dept. of Health, Offic	e of Health Ca Assuranc			, 0,	
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
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4.470	0 :		1			
4 173	Continued From pa	ge 8	4 173			9
				RAI Coordinator and back up I	RAI	-
	Finding includes:			Coordinator will be MDS Certi		1
,	-			by 5/1/2017.		17
				W 11	1	THE RESERVE OF THE PERSON OF T
				Weekly meeting with RAI	!	
				Coordinator and Chief Nurse Executive will be done to assur	_	1100
				timely completion of MDS	е	77
				assessments by 12/12/2016.		
				abbesides by 12/12/2010.		1
				During Daily Operation meeting		
				with clinical team (M-F) review		1
				all MDS due dates are discussed		
:				assure meeting MDS assessment		
				deadline by 12/12/2016.		
				How the corrective action will		
				monitored to ensure the deficie	ent	
				practice will not recur.		
ĺ				RAI Coordinator will meet with		
				Chief Nursing Executive on a		
				weekly basis starting on	.	
				and ongoing for the next 3 mont		
				to assure that all admission MDS	i i	
				are comprehensive, completed a submitted to the State prior to du		
				date.	16	
			i	date.		B
				Date(s) when corrective action		
				will be completed		ABL NAME A
			1	By 12/12/2016 and ongoing for	the	12/12/2016
				next 3 months.		,
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						10.00 mm m m m m m m m m m m m m m m m m
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AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ž.	MENDED POC				
		125031	B. WING		12/09/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
KOHALA	HOSPITAL	54-383 HC	SPITAL RO	AD	
KOHALA	THOSPITAL	KAPAAU,	HI 96755		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) .	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
	Continued From particles of care shall be deversident needs work services, med services, restor dietary or nutritional resident/family. This Statute is not Based on observational staff interviews dental care plan for	de 9 disciplinary care process d, interdisciplinary overall plan eloped to address prioritized including nursing care, social ical services, rehabilitative ative care, preventative care, requirements, and education. met as evidenced by: ons, medical record review the facility failed to develop a	4 173		e ents by up ment be t tal tto ure t l ng up nt nires sklist
				recommendations by Registere Nurse Educator starting 1/3/20 and ongoing.	

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Hawaii [Dept. of Health, Office	e of Health Ca Assuranc				APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
AMENDED PGC 125031		B. WING		12/09/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KOHALA	HOSPITAL		OSPITAL RO HI 96755	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
4 174	Continued From pa	ge 10	4 174	How the corrective action we monitored to ensure the definition practice will not recur. Assistant Nurse Manager will check all dental recommendate after annual evaluation and withere is a complaint of dental problems starting 1/6/2017 and assure follow up appointment scheduled.	tions hen	
4 175	(c) The overall plan periodically by the indetermine if goals changes are require and as necessitate condition. This Statute is not Based on observation interview with reside facility failed to revise.	isciplinary care process of of care shall be reviewed interdisciplinary team to have been met, if any ed to the overall plan of care, if d by changes in the resident's met as evidenced by: on, record review and ent and staff member, the se a care plan for 1 of 12 ipled residents.	4 175	Date(s) when corrective actio will be completed by 1/6/2017 and ongoing.	n i	1/6/2017

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Hawaii [Dept. of Health, Offic	e of Health Ca ssuranc			FORM.	APPROVED
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION WISNDED PGC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	SURVEY
7-13	VEND ID LOS	125031	B. WING	The second secon	12/0	9/2016
	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE AD	1 1270	7372010
		KAPAAU	, HI 96755			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		D BE	(X5) COMPLETE DATE
	Continued From pa	ge 11	4 175	4 198 11-94.1-46(0) Pharmaceutical Services What corrective action will be accomplished for those reside found to have been affected be the deficient practice. Pharmacist conducted medicative reviews by 1/16/2017. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. Pharmacist will review all reside assuring that medication review was done and is current by 1/16/2017.	e nts y on	
4 198	review the record or medications to do reactions, interaction. The review and any documented in the statute is not Based on medical reinterviews, the facility	nall, on a monthly basis, all residents receiving letermine potential adverse ns, and contraindications. concerns identified shall be	4 198	What measures will be put interpractice or what systemic changes you will make to ensure the deficient practice does not recur. RAI Coordinator will do audits quarterly at Interdisciplinary Teameetings to check that Pharmaci have completed medication revion residents that are due - starting January 2017 and ongoing. How the corrective action will monitored to ensure the deficient practice will not recur. RAI Coordinator will report to the quality team meeting completed Pharmacist medication reviews starting January 2017 and ongoing.	am ist ew ng be ent	

Office of Health Care Assurance STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
<u> </u>	Mended PC()		A. BOILDING	-		
		125031	B. WING TO SHAPE TO A SHAPE THE PROPERTY OF THE SHAPE OF		12/0	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
KOHALA	HOSPITAL		OSPITAL RO , HI 96755	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
4 198	Continued From pa	ge 12	4 198			
	11-94.1-53(a) Infection (a) There shall be procedures written prevention and contract shall be in complaws of the State as		4 203	Date(s) when corrective action will be completed By 1/16/2017 4 203 11-94.1-53(a) Infection Control What corrective action will be accomplished for those residen found to have been affected by the deficient practice. Chief Nurse Executive and Registered Nurse Educator instructed CNAs (working on the morning of 12/9/2016) on prope infection prevention and control program in cleaning shower chaw gurneys in-between resident us following manufacture's direction the equipment cleaning wipe on 12/9/2016. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. Chief Nurse Executive and Registered Nurse Educator inserviced all Clinical staff on the proper infection prevention and control program in cleaning shochairs & gurneys in-between resident use following manufacture's direction on the equipment cleaning wipes by 1/3/2017.	ne r irs ise on s	1/16/2017
	This Statute is not	met as evidenced by:				

Hawaii Dept. of Health, Office of Health Ca Assurance

Hawaii [Dept. of Health, Offic	e of Health C(Assuranc				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	amended poc					
	The state of the s	125031	B. WING	A CONTRACTOR OF THE CONTRACTOR	12/0	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KOHALA	HOSPITAL		SPITAL RO	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETE DATE
4 203	Continued From pa	ge 13	4 203			
	facility policy review	Based on observations, staff interviews and facility policy review, the facility failed to follow an infection prevention and control program.		What measures will be put into practice or what systemic changes you will make to ensu the deficient practice does not recur.	re	
	An observation of the morning of 12/9/16 found the shower of side of the room. In Nurses Aides, CNA revealed differing research	ne shower room on the at approximately 10:10 A.M. nairs/gurneys placed to the aterviews with 2 (two) Certified s, on the morning of 12/9/16 esponses to how they ar chairs/gurneys between		Orientation on all New Clinical Staff Hires on the proper infection prevention and control program cleaning shower chairs & gurne in-between resident use following manufacture's direction on the equipment cleaning wipes by 1/3/2017.	ın ys	
	An interview of CNA at approximately 10 red top CaviWipes to chairs/gurneys after wiping with the Cavused a towel to wipe shower chairs/gurnenext resident. An interview of CNA at approximately 10 red top CaviWipes to chairs/gurneys after Following use of Ca and dry the surface	A #1 on the morning of 12/9/16 :20 A.M. found she used the to wipe down shower each resident's use. After iWipes, she reported that she e off the solution from the eys before proceeding with the A #2 on the morning of 12/9/16 :25 A.M. found she used the to wipe down shower each resident's use. InviWipes, she would then rinse of the shower chair/gurney with the next resident.		How the corrective action will monitored to ensure the defici practice will not recur. Registered Nurse Educator will perform a skills check on 100% all CNAs and RNs on the prope infection prevention and control program in cleaning shower cha & gurneys in-between resident a following manufacture's direction the equipment cleaning wipe by 1/3/2017. Date(s) when corrective action will be completed By 1/3/2017.	of r irs ise on s	1/3/2017
	the morning of 12/9 A.M. revealed the s red top CaviWipes to chairs/gurneys betw further noted the CN shower chairs/gurne	Director of Nursing, DON, on /16 at approximately 11:00 taff were required to use the for cleaning the shower veen residents. The DON NAs were trained to allow the eys to dry (after CaviWipes) or the next resident.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
A(10) =	OF CONTROL	IDENTIFICATION NOWIDER.	A. BUILDING:		COMPL	_ETED
,	wended for	125031	B. WING		12/0	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
KOHALA	A HOSPITAL	54-383 HC	SPITAL RO	AD		
110111111	THOUTTAL	KAPAAU,	HI 96755			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
4 203	Continued From pa	ge 14	4 203		in the second se	
	policy titled, "Infection Precautions" with result of the "Patient Care Equipment is not us patient until it has be reprocessed, and sidiscarded."	12/9/16, a review of the facility on Control - Standard evision date of 6/17/14 found, oment; b) Ensure that reusable sed for the care of another seen appropriately cleaned and ingle use items are properly acility staff were not clear on releaning the shower ween residents.				