PRINTED: 01/31/2017
FORM APPROVED

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
	12G035	A. BUILDING: _____ B. WING _____	01/20/2017

RECEIVED
2017 APR 24 P 1:53
STATE OF HAWAII
DOH-OHCA MEDICARE

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARC IN HAWAII - EWA C	91-824 C HANAKAHI STREET EWA BEACH, HI 96706

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9 000	INITIAL COMMENTS The annual State re-licensure survey of the facility was conducted on 1/18/17 - 1/20/17 by the Hawaii State Survey Agency. At the time of entrance, there were five clients in the home.	9 000		
9 005	11-99-4(a) ACTIVE TREATMENT PROGRAM A plan of treatment shall be developed and implemented for each resident in order to help the residents function at their greatest physical, intellectual, social, emotional, and vocational level. This Statute is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide training to focus on skills and competencies directed toward client's health needs. Finding includes: On 1/18/2017 at 3:45 PM a medication pass was observed for Client #4 (C #4). The Hab Worker (HW) #1 gave C #4 medication with applesauce followed by water mixed with a spoonful of Thick It. C #4 drank the thickened water from an open cup, no lid. Later during mealtime C #4 was observed at the table drinking from an opened cup of milk mixed with a spoonful of Thick It, no lid on the cup. A review of C #4's record found documentation of a nutrition assessment dated 8/12/2015 with recommendation for "liquids in cup with lid and small opening to limit gulp" due to dysphasia with difficulty swallowing. A review of C #4's current Physician's Orders found a diet order that stated, "liquids in cup with lid and small opening to limit gulp". A review of C #4's Health Maintenance Plan found documentation for a problem on "dysphasia: difficulty swallowing".	9 005	11-99-4(a) ACTIVE TREATMENT PROGRAM Plan of Correction Nurse Manager and Home Manager (HM) reviewed the proper swallow guidelines for Client #4 with home staff. RN will train all home staff on proper swallowing guidelines and using a cup with a lid and a small opening for Client #4. Systemic Each assigned RN will review all swallow guidelines for each home with the homes assigned HM. HM will then train all staff in their home on each client's swallow guidelines. Quality Assurance HM's to observe and monitor on a daily basis and retrain staff as needed.	1/23/17 3/15/17 3/30/17 Daily

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

Director of Programs & Services 4/21/17

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9 005	Continued From page 1 With an intervention that included use of the lidded cup for liquids. On 1/19/2017 the Licensed Nurse (LN) #1 was interviewed and asked about use of the lidded cup use in the home. The LN #1 stated after follow up with the home manager and program, it was found that the lidded cup is used in program but not in the home. The facility failed to follow up on staff training in the home to meet client's dysphasia health needs.	9 005	11-99-4(a) ACTIVE TREATMENT PROGRAM(Continued) RNs to observe and monitor during quarterly observations and train or retrain HM or staff as needed.	Quarterly
9 151	11-99-15(b) INFECTION CONTROL There shall be appropriate policies and procedures written and implemented for the prevention and control of infections and the isolation of infectious residents. This Statute is not met as evidenced by: Based on observations, interviews, and policy review the facility failed to ensure handwashing policy and practices are following consistently for the control of communicable diseases and infections, including the instruction of other personnel methods of infection control. Findings include: 1) On 1/18/2016 at 11:00 AM observed a meal observation for C#3 and C #2, and another random Client. The meal was assisted by the Instructor Assistant (IA) #1. C #2, C #3, and the random client were seated at a picnic table. IA #1 stood between C #2 and C #3 and across the random client. Without hand sanitizing IA #1 touched the spoon of C #2; rearranged the plastic containers and touched the spoon of the random client; touched the spoon and used a napkin to wipe the mouth of C #2; refilled the cup of the	9 151	11-99-15(b) INFECTION CONTROL Plan of Correction Nurse Manager and Home Manager (HM) reviewed with both home and ADH staff the importance of following handwashing policies and practices. RN to train all Ewa C home staff and all Wahiawa Center staff on proper handwashing policies and practices to include proper use of hand sanitizer, using soap, washing hands in between working with different clients, and in between tasks. RN to also include in training of Ewa C home staff, proper disinfection and sanitation of all personal hygiene products including toothbrushes.	1/23/17 3/15/17 3/15/17

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9 151	Continued From page 2 random client with water; added a spoon of thicket to the random clients cup; and again touched the spoon of C #2. Between assisting the three clients, IA#1 was observed eating french fries. After the observation IA#1 was asked about hand sanitizing between client care and eating. IA#1 stated, "I suppose to hand sanitize between clients." Later that evening interviewed LN #1 to discuss the meal observation, LN #1 stated there should be hand sanitizing between client care. On 1/19/2017 the facility's Infection Control Policy and Procedure was reviewed and states, "3. Implement Personal Health and Cleanliness Practices. Washing hands frequently or use cleansing wipe between touching clients"; and "4. Wash hands: before eating". The facility failed to follow proper hand sanitizing policy between client care and prior to eating as an infection control prevention measure. 2) On 1/18/2017 at 3:15 PM during a medication pass observed HW #1 apply hand sanitizing gel to C #3's hands, assist with rubbing the fisted hands together then use a paper towel to wipe off the excess sanitizing gel that remained on C #3's hands. At 3:55 PM observed HW #1 apply hand sanitizing gel to C #2's hands, encourage C #2 to rub hands together, then wipe off the excess sanitizing gel on C #2's hands. After the observation the HW #1 was asked the purpose of letting the gel dry on the client's hands without wiping. The HW #1 stated, "yes, to kill the germ". Later that evening at 4:05 PM interviewed the LN #1 regarding the observation of wiping off the sanitizing gel from the client's hands. The LN #1 stated, "wiping the gel off, that defeats the purpose of sanitizing". On 1/19/2017 a review of the facility's training on how to use hand sanitizers, states, "Rub the product over all	9 151	11-99-15(b) INFECTION CONTROL (Continued) Systemic Each assigned RN will review with respective HM's, proper handwashing policies and procedures as well as proper disinfection and sanitation practices of personal hygiene products. Each HM will train all of their home staff on proper handwashing policies and procedures as well as proper disinfection and sanitation practices of personal hygiene products. Quality Assurance HM's to observe and monitor on a daily basis and retrain staff as needed. RNs to observe and monitor during quarterly observations and train or retrain HM or staff as needed.	3/30/17 Daily Quarterly

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9 151	Continued From page 3 surfaces of your hands and fingers until your hands are dry." The facility did not follow hand sanitizing use recommendations by failing to leave the product to dry on the hands for germ reduction. 3) Observation of the breakfast meal on the morning of 1/19/17 at 6:00 A.M. found a Habitation Worker, HW#2, assisting Client #1 with breakfast. Without washing/sanitizing her hands first, HW #2 was observed removing a carton of ice cream from the freezer, removing a bowl from the cupboard, scooping out the ice cream, opening a container of "Thick It", scooping thickener out and pouring it into the ice cream bowl, stirring the "Thick It" into the ice cream, then began spooning the ice cream into Client #1's mouth. 4) Observation of morning care on the morning of 1/19/17 at approximately 7:10 A.M. found HW #2 pushing Client #1's wheelchair into the bathroom. At the bathroom sink, HW #2 rinsed her hands with water and did not use soap. The HW #2 placed toothpaste on Client #1's toothbrush but realized she forgot a cup to rinse the client's mouth. She placed the toothbrush (with the toothpaste on it) on the side of the sink. The HW #2 then went to a closet immediately outside of the bathroom, opened the closet door, didn't see a cup in there, then shut the door. The HW #2 then went to the kitchen to get a cup. Upon her return, the HW #2 did not sanitize/wash her hands. She began brushing Client #1's teeth. 5) Observation of morning care on the morning of 1/19/17 at approximately 7:15 A.M. found HW #2 and the Home Manager repositioning Client #1 in her wheelchair. The HW #2 bumped Client #2's toothbrush caddy and it fell to the floor.	9 151	This page intentionally left blank.	

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9 151	Continued From page 4 Client #1's two toothbrushes and toothpaste fell on the floor. The Home Manager informed the HW #2 that she needed to wash those items. The HW #2 was observed rinsing the toothbrushes and toothpaste with water. She placed the items back in the caddy and returned the caddy to Client #1's bedroom. Interview of the Licensed Nurse, LN #1, on the morning of 1/19/17 revealed HW #2 should have washed her hands before she started feeding Client #1. The LN #1 also expected HW #2 to wash her hands before brushing Client #1's teeth. Finally, LN #1 stated that HW #2 should have discarded the toothbrushes and replaced with new ones. A review of the facility's policy titled, "Infection Control Policy and Procedure", noted, "4. Practice proper hand washing techniques: Wash hands - Before eating, drinking, smoking, handling clean utensils and equipment, handling food."	9 151		
9 270	11-99-29(a)(1) RESIDENT'S RIGHTS Written policies regarding the rights and responsibilities of residents during their stay in the facility shall be established and shall be made available to the resident, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. The facility's policies and procedures shall provide that each individual admitted to the facility shall: Be fully informed, as evidenced by the resident's or guardian's written,	9 270	11-99-29(a)(1) RESIDENT'S RIGHTS Plan of Correction and Systemic The facility will develop a policy and procedure for the use of live video cameras. The policy and procedure will include methods in which the use of live video cameras will be reviewed by The Arc in Hawaii's Human Rights Committee, and that informed consent will be obtained from all guardians that reside in a home where live video cameras will be/are in use.	3/30/17

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9 270	Continued From page 5 signed acknowledgment prior to or at the time of admission and during stay, of these rights and of all regulations governing resident conduct. This Statute is not met as evidenced by: Based on observations, staff interviews, and facility policy review, the facility failed to develop policies and procedures for the use of live video cameras in the home, affecting all five clients. Findings include: The facility was utilizing four live feed video cameras in the home. In an interview of the ICF Program Manager on the afternoon of 1/19/17, she reported that the facility did not develop policies and procedures for the use of video cameras. Additionally, the facility failed to obtain informed consents from all clients for the use of the cameras. Finally, the facility failed to have the Human Rights Committee review the use of video cameras in the home.	9 270	11-99-29(a)(1) RESIDENT'S RIGHTS (Continued) Quality Assurance The policy and procedure for live video cameras will be reviewed periodically and revised as needed.	On-going
9 279	11-99-29(a)(10) RESIDENT'S RIGHTS Written policies regarding the rights and responsibilities of residents during their stay in the facility shall be established and shall be made available to the resident, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. The facility's policies and procedures shall provide that each individual admitted to the facility shall: Be treated with consideration, respect and full recognition of their dignity	9 279	11-99-29(a)(10) RESIDENT'S RIGHTS Plan of Correction All authorized viewers were instructed not to view the Ewa C live video feed until such time that The Arc's Maintenance department could uninstall the monitor in Client # 1's bedroom. Live video monitor in Client #1's bedroom was removed by the facilities Maintenance department.	1/2 1/17 2/21/17

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9 279	Continued From page 6 and individuality, including privacy in treatment and in care. This Statute is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure the opportunity for personal privacy for all 5 clients in the home. Findings include: Observations on the morning of 1/19/17 at approximately 6:00 A.M. found the clients in various locations in the home. Client #1 was in the kitchen. Client #2 was seated in the living room in front of the TV. Client #3 was asleep in her bedroom. Client #4 was seated in a recliner in the living room. Client #5 was seated in her wheelchair next to the dining room table. The home contained four live feed video cameras. Three of the cameras were situated on two sides of the common living areas and one camera was mounted on the wall in Client #1's bedroom. Camera #1 was mounted approximately 7-8 feet high on the wall between the laundry room and the kitchen. Camera #1 was positioned towards the dining room and living room with the bedrooms at the far end. The Home Manager reported that Camera #1 did not capture images in the bedrooms of the clients. Camera #2 was mounted approximately 7-8 feet high in the hallway between Clients #2 and #3's bedrooms. Camera #3 was mounted approximately 7-8 feet high in the corner between Clients #4 and #5's bedrooms. Cameras #2 and #3 were facing the living room and dining room with the kitchen and laundry room at the far end. Camera #4 was mounted approximately 7 feet high on the wall on the same side of the door to Client #1's bedroom. Camera #4 was facing	9 279	11-99-29(a)(10) RESIDENT'S RIGHTS (Continued) Systemic and Quality Assurance Live video monitors were removed from all Client's bedrooms that had video monitors. To ensure personal privacy for all clients, it will be documented in The Arc's new policy and procedure for live video cameras that no live video will be installed in any way in any Client's bedrooms. 11-99-29(a)(10) RESIDENT'S RIGHTS (Continued) Plan of Correction Informed Consent, which will include the location of and who has access to the live video cameras as well as the reasons for use, will be obtained from all guardians of Ewa C participants for the use of live video cameras in the common areas of the Ewa C home. The use of the live video cameras in the common areas of the Ewa C home will also be reviewed by The Arc's Human Rights Committee.	2/21/17 3/30/17

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9 279	Continued From page 7 Client #1's bed. An interview of the Home Manager on the morning of 1/19/17 at approximately 6:39 A.M. revealed the facility leaves the camera facing the client's bed all the time. According to the ICF Program Manager, the live feed video cameras record all activities but only three people have access to viewing: the Executive Director; ICF Program Manager; and the Director of Programs and Services. The ICF Program Manager reported that only those three persons have passwords to get into the live feed. Client #1 is alert and able to communicate using a special language system. An interview of the ICF Program Manager on the morning of 1/18/17 at approximately 9:30 A.M. revealed Client #1 previously made allegations of neglect/abuse towards the home staff members. The ICF Program Manager conducted investigations after the allegations were made and re-interviewed Client #1. Client #1 recanted the allegations after staff members provided their accounts of the events. Client #1 poses many challenges to the facility including the fact that her family is insisting that the facility provide one to one care in the home. The facility informed the family that they were not equipped nor were they required to provide one to one care. According to the ICF Program Manager, the facility is working with the family in assisting them with transferring the client to another facility. An interview of the Home Manager on the morning of 1/19/17 at approximately 6:30 A.M. revealed Client #1 previously made allegations of neglect towards the home staff. Client #1 communicates complaints to her family, who then contacts the facility with the client's complaints.	9 279	11-99-29(a)(10) RESIDENT'S RIGHTS (Continued) <u>Systemic</u> Informed Consent, which will include the location of and who has access to the live video cameras as well as the reasons for use, will be obtained from all guardians of all ICF homes with live video cameras in common areas. The use of the live video cameras in the common areas of any ICF home will also be reviewed by The Arc's Human Rights Committee. Prior to installation of any new live video cameras in common areas of an ICF home, The Arc will obtain informed consent from all guardians of Clients within that home and have the use of the live video cameras reviewed by The Arc's Human Rights Committee. <u>Quality Assurance</u> CM's will review informed consent of live video cameras with guardians annually at each client's IPP. RN's will review the use of live video cameras with The Arc's Human Rights Committee annually.	3/30/17 On-going Annually Annually

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9 279	Continued From page 8 The family is adamant about Client #1 receiving one to one care. The Home Manager reported they are not equipped to provided one to one care. They provide as much attention as they can and sometimes Client #1 does receive one to one care. A record review on the morning of 1/19/17 for Client #1 found an "Informed Consent of Video Monitoring System" dated 12/2/15 and noted, "(Expires in one year)", indicating an expired consent form. Additionally, the Consent only listed the client's name, home identification, diagnoses, medical history, and purpose. The purpose stated, "Safety maintenance. Ensure staff support." The Informed Consent did not explain that the video camera was situated in the client's bedroom, which compromised Client #1's personal privacy. An interview of the Home Manager on the morning of 1/19/17 at approximately 7:10 A.M. revealed that Client #1's clothing is changed in her bedroom, in view of the video camera. The Home Manager further noted that Client #1 uses the bedside commode, also in view of the video camera. On the morning of 1/19/17, record reviews for Clients #2, 3, 4, and 5 found the facility failed to obtain consent for video monitoring. An interview with the ICF Program Manager on the morning of 1/19/17 revealed the facility made a decision to send out notifications for the use of live video cameras rather than obtain informed consents with guardian signatures for Clients #2, 3, 4, and 5. Additionally, the ICF Program Manager reported they did not have a policy and procedure for the use of live video cameras. Finally, the facility did not review this issue in the Human Rights Committee.	9 279	This page intentionally left blank.	