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	125059	A. BUILDING: _____ B. WING _____	02/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOLO CHINESE HOME	2459 10TH AVENUE HONOLULU, HI 96816

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4 000	Initial Comments A re-licensing survey was completed on 02/01/2019. The facility had 113 licensed beds with 103 beds occupied.	4 000		
4 118	11-94.1-27(7) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (7) The right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive; □ This Statute is not met as evidenced by: Based on interviews and record review (RR), the facility failed to provide documentation that residents or their representatives were given opportunities to formulate Advance Directives (AD) for three residents (R) 47, R72, and R78 of 31 residents selected for review. Findings Include: 1) On 01/30/2019 at 8:37 AM, RR for R78 showed no AD. On 01/30/2019 at 11:37 AM, Clinical Clerk (CC) 5 informed surveyor she was unable to locate an AD for R78.	4 118	1. On 01/30/2019 the Social Service Coordinator (SSC) met and was provided written information on completing an Advance Directive, facility□s policies to implement Advance Directives and form with R78 who stated that he was not interested in establishing an Advance Directive. Resident R47 was incapacitated therefore on 02/08/2019 SSC called R47□s brother and informed him of the option of completing a Surrogate Decision Making form. He was instructed to meet with her for the form and instructions on completion. On 01/30/209 SSC called R72□s son if the resident had an Advance Directive. He did	2/14/19

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4 118	Continued From page 1 2) R72 was recently admitted to the facility on 01/05/2019. Record review revealed R72 had a POLST, but no AD in the clinical hard chart. On 01/30/2019 at 8:57 AM, the Clinical Support Manager (CSM) stated the social worker, "is responsible to follow up for advance directives" on admission and/or with family. On 01/30/2019 at 9:03 AM, during a concurrent record review, the CSM confirmed the social worker only checked off the POLST but had no AD review/documentation on her initial assessment for R72. On 02/01/2019 at 12:02 PM, registered nurse (RN) 1 reviewed R72's durable power of attorney form and concurred it was not an AD for health care decisions, but for financial decisions only. 3) On 01/30/2019 at 1:06 PM, the RR on R47 found there was no AD. The facility's "Acknowledgement" form that R47 signed on admission had initialed with a check mark at, ". . .7. I do not have a living will or Advance Directives and am interested in completing an Advance Directive . . ." On 01/31/2019 at 11:04 AM interviewed the social worker coordinator (SWC) and inquired how she would be alerted that a resident at the facility was interested in developing an Advance Directive. The SWC stated that the admission clerk would alert social services and a social worker would then follow-up with the resident to get an AD done. The SWC was not aware of R47's request for AD on the facility's "Acknowledgement" form, as she just started in September 2018 and R47 was admitted in 2016.	4 118	not, subsequently the resident was discharged on 02/01/2019 and a copy of the form and instructions to establish an Advance Directive was sent to the resident and family on 02/14/2019. All the information was documented in the medical record. On 02/13/2019 RN1 was educated on the difference between a financial power of attorney and Advance Directive. 2. On 02/11/2019, the Social Services Coordinator audited all resident□s medical records for an Advance Directive and called resident□s families to bring a copy in if they had one. If there were no Advance Directives in the medical record and there were none established the SSC met with the resident and was informed of and provided written information/description of the facility□s policies/form to implement an Advance Directive OR documented in the medical record for those residents not interested or incapacitated in establishing one. For those residents who were incapacitated the family members were informed and provided written information on the Surrogate Decision Making option. The SSC will follow-up with families at least every quarter or with any changes with resident capacity/family decision. 3. On 01/31/2019 the Clinical Support Staff which included admissions, medical records, minimum data set coordinators and social service coordinators were educated by the Manager of Clinical Support on the Advance Directive policy and procedure. On 02/13/2019 all Clinical Support Staff were in-serviced on the revised Admission Handbook, Admission	

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4 118	Continued From page 2 On 02/01/2019 at 7:30 AM, interview with Clinical Support Manager (CSM) who confirmed the facility does not have a process for follow-up regarding AD. CSM stated they are working on a process and will have one soon.	4 118	Resident and Family forms with the updated Advance Directive form and written information. On 02/14/2019, a mandatory facility wide in-service was completed to educate the staff on the revised Advance Directive policy. Staff was educated on the difference between a financial power of attorney and an Advance Directive. 4. On 02/14/2019 the Social Worker or Designee will audit monthly for a filed Advance Directive/Surrogate Decision-Making form or documentation that each resident and/or family (if resident is incapacitated) was informed and provided written information on their right to formulate an Advance Directive including a written description of the facility□s policies each quarter or with capacity/family decision changes. Findings, progress and corrective actions will be reported to the QA committee quarterly.	
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 and responsibilities, formulary, storage,	4 185		2/14/19

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4 185	Continued From page 3 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 and interviews, the facility failed to prepare and administer one medication for one resident (R) 4 of 31 residents selected for review. This deficient practice had the potential to cause the resident discomfort or jeopardizes his or her health and safety. Findings Include: On 01/31/2019 at 7:38 AM, observation of medication administration for R4 on Ilima Unit with Registered Nurse (RN) 6. R4 had the following medications: [redacted] RN6 proceeded to crush all of R4's pills in a small clear plastic zip lock bag. RN6 was queried by surveyor if there was a physician's order to crush the pills, RN6	4 185	1. On 01/31/2019, DON re-educated RN 6 that EC (Enteric Coated) medications should not be crushed. 2. On 02/04/2019, DON checked all the Enteric Coated medication orders. All EC orders were re-transcribed and added Do Not Crush Medication to the order. On 02/12/2019, DON/Designee observed medication administrations for residents with EC medications and validated that the proper administration of enteric coated medications, of not being crushed. The licensed nurses administered the Aspirin EC as a whole pill and was in compliance with the policy. 3. On 02/05/2019, DON/Designee in-serviced the nursing staff that EC medication should not be crushed. On 02/11/2019, Medications Not to Be Crushed List was provided to each nursing units. On 02/12/2019, DON/Designee in-serviced the licensed nurses on the Medication Administration General Guidelines policy. On 02/14/2019, a facility wide in-service was done with the PCH staff by the DON. 4. DON/Designee will observe	

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4 185	Continued From page 4 stated "Yes" there was. Surveyor questioned if all the pills were to be crushed, RN6 said "yes." Surveyor queried RN6 if the Aspirin EC was to be crushed, RN6 thought for a moment and stated, "No." 01/31/2019 at 7:45 AM, Interviews with DON and ADON who both confirmed that Aspirin EC 81mg should not have been crushed.	4 185	medication administrations monthly of residents with enteric coated medications that it is administered correctly and not crushed by the licensed nurse. Findings, progress and corrective actions will be reported to the QA committee quarterly.	
4 204	11-94.1-53(b)(1) Infection control (b) The facility shall have provisions for isolating residents with infectious diseases until appropriate transfers can be made. (1) The facility shall have a written policy that outlines proper isolation and infection control techniques and practices; This Statute is not met as evidenced by: Based on observations, interviews and policy reviews the facility failed to ensure that policies and procedures for infection control measures implemented to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment were being followed. 1) Visitors entered the room (RM) without donning personal protective equipment (PPE) for one of 31 sampled residents, (R) 46 on contact precautions; and, 2) The facility failed to clean the suction equipment/canister for one of the eight residents (R) 68 reviewed. These deficient practices put the residents at risk for the development and transmission of communicable diseases and infections.	4 204	Contact Precautions and PPE use 1. On 01/31/2019, R46□s husband and housekeeper 8 were instructed to use gown and gloves when entering R46□s room. On 02/01/2019, licensed nurse was educated that she is responsible to ensure that all contacts with resident with precautions must use the proper personal protective equipment (PPE) before entering the room. On 02/11/2019, the DON called the transporter company and provided education for transporters to follow infection control/PPE instructions posted on the resident□s door. 2. On 02/08/2019, Director of Nursing (DON)/Designee observed that all staff and visitors used the proper PPE before	2/14/19

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4 204	Continued From page 5 Findings Include: 1) Contact Precautions and PPE use On 01/30/2019 at 9:24 AM the electronic record review (RR) on R46 noted on the 12/31/18 monthly summary that R46 tested positive for [redacted] On 01/31/2019 at 8:20 AM observed R46 being prepared for transport with certified nursing assistant (CNA) 6 wearing personal protective equipment (PPE) in the RM, and the spouse at the bedside without PPE on. The transport driver also walked into R46's RM without putting on PPE and the spouse assisted the transport driver in transferring R46 from the bed to the transport gurney. Both the spouse and transport driver left the RM with R46 on the gurney, walked through the common hallway and passed the activity/dining area to the transport van outside. Interviewed CNA6 about PPE use for visitors and she stated that the spouse normally wears PPE but didn't know why PPE not used on this date. Interviewed RN2, and she stated that R46 was transported to an acute care hospital to have GT changed. Shared observation with RN2 of spouse and transport driver not wearing PPE, with R46 on contact precautions for MRSA. RN2 stated that the spouse normally wears PPE, but didn't have an answer for the transport driver who was under contract for transportation. On 01/31/2019 at 10:16 AM R46 returned to the	4 204	entering resident rooms with infection control precautions. On 02/08/2019 the nursing staff was educated that they are responsible to ensure that all contacts □ staff and visitors, with resident with infection precautions must use the proper personal protective equipment (PPE) before entering the room. 3. On 02/05/2019, the DON in-serviced the nursing staff that everyone including family members, visitors, transporters entering a resident□s room with an infection must use the proper PPE as required by the infection control policy. On 02/08/2019, the DON removed the Happy Face sign for all residents with infection control precautions and replaced it with the new Contact Precaution sign. The Contact Precaution sign is printed in red with pictures of PPE required to enter the room. On 02/11/2019, the DON notified all transporter companies and provided education for their drivers to follow infection control instructions posted on the resident□s door. On 02/12/2019, the Environmental Service Manager in serviced the housekeepers and the laundry staff of the new Contact Precaution sign and the infection control requirements to follow and wear PPE. On 02/12/2019, the DON in-serviced the nursing staff of the new Contact Precaution sign and the infection control requirements to wear PPE. On 02/14/2019, a facility wide in-service was done with the PCH staff on the Contact Precaution signage and infection control requirements on PPE. 4. The DON/Designee will observe the nursing staff, family members, visitors,	

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4 204	Continued From page 6 facility and observed CNA6 in R46's RM with PPE on, and the spouse entered the facility from outside with PPE on. The spouse was about to enter R46's RM but CNA6 stopped spouse at the door and stated that PPE needed to be changed. Interviewed the spouse who stated that PPE was not used when transported R46 earlier in the morning because just came to pick-up resident and didn't want to waste PPE. The spouse stated that instructions on PPE use was provided. Subsequently, observed that housekeeper (Hskpr) 8 walked into R46's RM without PPE on. The Hskpr8 delivered clean laundry and placed into R46's closet. Interviewed Hskpr8 and inquired if PPE used for residents on contact precaution. The Hskpr8 stated that he should use PPE for residents on contact precaution and would know by the contact precaution sign (smiley face picture) on the door. Pointed out that R46 had a smiley face picture on the door and PPE were in plastic drawers fronting the RM. The Hskpr8 was unaware that R46 was on contact precautions, and didn't notice smiley face sign as door was opened inward to the left of doorway. The Hskpr8 then put on PPE and delivered clean laundry to R46's roommate. On 01/31/2019 at 10:40 AM requested PPE policy and procedure for residents on contact precaution from unit manager (UM) 1. The facility's policy and procedure for "Standard Precaution/Use of PPE," under the paragraph "Personal Protective Equipment (PPE); a. Wear PPE when the nature of the anticipated resident interaction indicates that contact with blood or body fluids may occur. ; b. Prevent contamination of clothing and skin during the	4 204	housekeeper, laundry department, and transporters that proper PPE is used before entering a resident□s room with infection precautions. Findings, progress and corrective actions will be reported to the QA committee quarterly. Cleaning and Disinfection of Resident Care Equipment 1. On 01/30/2019, the suction equipment/canister was discarded. 2. On 01/30/2019, DON/Designee checked all the rooms if there are any used/uncleaned suction cannister with contents. None were found. 3. On 02/12/2019, DON/Designee in-serviced the nursing staff of the new policy and procedure Proper Disposal of Used Suction Waste Collection Canisters. PCH will discard suction equipment/canister daily or when more than half full. On 02/14/2019, a facility wide in-serviced was done with the PCH staff. 4. DON/Designee will do environmental rounds daily to check that suction equipment/canisters are disposed of daily. Findings, progress and corrective actions will be reported to the QA committee quarterly.	

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4 204	Continued From page 7	4 204		

process of removing PPE. (see PPE removal procedure); c. Before leaving the resident's room or cubicle, remove and discard PPE."

The facility's policy and procedure for "Standard Precautions," with revision dates of 05/05/2008, and 12/15/2017 under the column for "Room Signage," had comments, "Use 'Happy Face' for non-C-Diff infections. Use 'Sad Face' for C-Diff or similar infections."

Interviewed the director of nursing (DON) and shared above observations. The DON stated that all facility staff are aware that the smiley face picture on a resident's door means that the resident(s) are on contact precautions. The DON could not provide an answer for the contracted transport driver not wearing PPE but was aware that the spouse usually wore PPE.

The facility did not a an infection prevention and control program that included a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases that covered visitors, and other individuals providing services under a contractual arrangement.

2) Cleaning and Disinfection of Resident Care Equipment

During an observation of the suction equipment in R68's room, on 01/29/2019 at 9:45 AM, the suction equipment/canister contained approximately 10 cc of white/brown liquid contents. The resident was not in the room and there was no way to determine how long the contents was in the canister. The canister was marked with the date 01/12/2019.

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4 204	Continued From page 8 During staff interview with the UM1 on 01/29/2019 at 9:53 AM, UM1 did not know how long the white/ brown contents was there. UM1 further acknowledged that the white/ brown contents should have been properly disposed of. After further inquiry with the DON on 01/30/2019 at 9:26 AM, she provided the policy on "Reprocessing of Suction Machines," which stated - This facility will provide guidelines for the proper cleaning and disinfecting of reusable medical equipment after its use. Cleaning and disinfection; remove the used suction canister and empty any contents into the utility sink. Turn on water to thoroughly flush contents down the drain. This was not done.	4 204		
4 246	11-94.1-64(d) Engineering and maintenance (d) The facility shall maintain records that document that inspection of all devices essential to the health and safety of residents and personnel shall be carried out at sufficient intervals to ensure proper operational performance. This Statute is not met as evidenced by: Based on observation, staff interview, and review of manufacturer's recommendation, the facility failed to perform routine maintenance and failed to keep preventative maintenance records for two out of two oxygen concentrators reviewed. This deficient practice put the residents at risk for the development and transmission of communicable diseases and infections. Findings Include:	4 246	1. On 01/30/2019, the cabinet filter for the oxygen concentrator for R15 was cleaned with soap and water, checked for any damages, and air dried before reinstalling the cabinet filter by the DON. 2. On 01/30/2019, the DON/Designee checked and cleaned all the oxygen concentrator cabinet filters as needed. 3. On 02/12/2019, DON/Designee in-serviced the nursing staff and reviewed the policy and procedure on Cleaning the	2/14/19

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4 246	Continued From page 9 During an observation on 01/30/2019 at 9:00 AM, resident (R)15 was noted to be receiving oxygen via an oxygen concentrator. Upon further observation of the oxygen concentrator, the cabinet filter was noted to be dirty containing lint and dust. For resident safety, R15 was briefly assessed and did not appear to be in any acute respiratory distress. During an interview with the Unit Manager (UM)1 on 01/30/2019 at 9:05 AM, UM1 stated that all routine maintenance for the oxygen concentrators were done by maintenance personnel. During an interview with the Maintenance Manager (Maint Mgr), on 1/30/2019 at 11:30 AM, Maint Mgr said that the facility was not aware of any routine maintenance, cleaning of the cabinet filter recommendation, and thus was not being done as per manufacturer's recommendation. Maint Mgr went on and said that he would immediately take care of this matter. A review of the instruction manual for the Devilbiss Oxygen Concentrator stated the following: Caring for your Devilbiss Oxygen Concentrator, Air Filter - the air filter should be cleaned at least once a week. As previously mentioned, the facility was not aware of this recommendation.	4 246	Cabinet Filter of Oxygen Concentrator. The nursing staff is to check and ensure that the oxygen concentrator cabinet filter is clean before issuing it to the resident requiring oxygen therapy. Night licensed nurse on Sundays to sign off that cleaning has been completed for the currently in use oxygen concentrators. On 02/14/2019, a facility wide in-serviced was done with the PCH staff. 4. DON/Designee to audit the cabinet filters of oxygen concentrators that they are cleaned every week. Findings, progress and corrective actions will be reported to the QA committee quarterly.	