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
	12G043	A. BUILDING: _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITIES AND RESOURCES, INC (HOL	64-1510 KAMEHAMEHA HIGHWAY WAHIAWA, HI 96786

(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
9 000	INITIAL COMMENTS A relicensing survey was conducted by the Office of Health Care Assurance from July 28, 2021 to July 29, 2021. The facility was not in compliance with Title 11, Chapter 99, Subchapter 1, Small Intermediate Care Facilities for Individuals with Intellectual Disabilities. Survey Census: 3	9 000		
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, staff interview and review of policy, the facility failed to maintain proper hand hygiene/infection control measures during the following instances: 1) Performing blood glucose testing for Resident (R) 1, 2) Administering medications for Resident (R) 3 and 3) Administering medications for Resident (R) 2. As a result of this, the facility put all three residents at risk for the transmission of infections and/or communicable disease. Findings Include: 1) During an observation on 07/28/2021 at 3:06 PM of blood glucose testing for R1, Caregiver (C) was observed to sanitize hands, put on gloves, then proceed to perform blood glucose test for R1. After performing the test, C did not remove the gloves but went to the medication closet and opened the door, to retrieve a sharps container,	9 151	Correction: The caregiver and other staff were given re-training on the procedure of using disposable gloves, including when to changes the gloves. Caregiver were provided with a copy of hands-out on how to properly dispose	08/10/21 08/10/21

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9 151	Continued From page 1 while wearing the same gloves. C retrieved the sharps container and disposed of the used lancet. C then opened the medication closet again with the same gloves and returned the sharps container. C used a disinfecting wipe to wipe the blood glucose machine and wipe the table while using the same gloves. C then removed gloves and sanitized hands. 2) During a second observation on 07/29/21 at 06:45 AM, C was observed to sanitize hands, put on gloves, then proceed to put fingers in R3 ' s pill bottle in order to retrieve some pills. 3) During a third observation, on 07/29/21 at 06:46 AM, after C administered the pills to R3, C removed the gloves and put on new gloves. However, there was no hand hygiene between the removal and application of the new gloves. C then proceeded to administer eye medications to R2. On 07/29/21 at 12:05 PM, Registered Nurse (RN) was asked about the proper hand hygiene, infection control measures for the events previously mentioned. RN said that they continuously perform education and training to staff, but acknowledged that proper hand hygiene/infection control measures were not followed in those instances. A review of facility policy on Hand Hygiene read the following: Staff Training, Staff training on hand hygiene will be provided to new staff within two weeks of hire and to all staff on an annual basis and updated as new information becomes available. The PC CM/QIDP, RN and other trained personnel will monitor staff to ensure policies and procedures of hand hygiene are implemented properly. Hands are washed	9 151	Continued from page 1: and when to change the gloves. Future Plan: The RN will check the house at least twice a week to ensure that the caregiver knows how and when to change and dispose the gloves. Training for proper hand washing will be done once a month and as needed to ensure that caregiver and other staff are properly using and/or disposing the disposable gloves, the RN will train the caregiver and other staff during the visit if necessary to ensure that the caregiver and reliever will be properly educated on better hygiene including when and how to properly dispose and change disposable gloves.	

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9 151	Continued From page 2 without recontamination (Infection Control).	9 151		
9 194	11-99-22(g)(1) PHARMACEUTICAL SERVICES All drugs shall be kept under lock and key except when authorized personnel are in attendance. This Statute is not met as evidenced by: Based on observations, staff interview, review of policy, and review of manufacturer precautions, the facility failed to secure two tubes of Denta Cream medication prescribed for Resident (R)3. Findings Include: During observation of the ORI 3B home on 07/28/21 at 3:30 PM, two tubes of Denta 5000 Plus Dental Cream was found in R3 ' s bathroom cabinet. There was no lock on the cabinet and the cabinet door could open easily. The label on both medications read Denta 5000 Plus Brand 1.1% Sodium Fluoride Prescription Dental Cream 5000 ppm Fluoride Plus Mild Cleaning System. On 07/28/21 at 03:32 PM, Caregiver (C) was asked about the unsecured medications. C stated that they do not monitor the contents of the cabinet because R3 becomes upset when anyone touches the cabinet. On 07/29/21 at 12:00 PM, Registered Nurse (RN) was asked about the unsecured medications. RN acknowledged that all medications, including the Denta Cream, should be secured/locked. Review of facility policy on storage and handling of drugs stated the following: General, Proper procedures for the storage and handling of drugs shall be followed by the residential staff	9 194	Correction: The Denta 5000 Plus Dental Cream have been placed in a lock cabinet together with other prescribed medications. The caregivers were advised that all prescribe medications shuold be place in a lock cabinet at all times. Future Plan: RN will check the house at least twice a week to ensure all prescribe medications are place in a lock cabinet at all times.	07/29/21 07/29/21

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9 194	Continued From page 3 responsible for the handling or administration of drugs. Storage and shelving, Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security as in accordance with Domiciliary home regulations (Chapter 89), and Small ICR-MR Regulations (Chapter 99). All drugs shall be kept under lock and key except when authorized personnel are in attendance. No unauthorized persons shall have access to storage cabinets or areas. Review of the Denta 5000 Plus Dental Cream manufacturer precautions read the following "Accidental ingestion of large amounts of fluoride may result in acute burning in the mouth and sore tongue. Nausea, vomiting, and diarrhea may occur soon after ingestion (within 30 minutes) and are accompanied by salivation, hematemesis, and epigastric cramping abdominal pain. These symptoms may persist for 24 hours".	9 194		
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 and individuality, including privacy	9 279		

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9 279	Continued From page 4 in treatment and in care. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to treat Resident (R) 2 with respect and dignity. Findings Include: During an observation on 07/28/21 at 05:00 PM, Care Reliever (CR) 1 was noted to be standing over R2 while R2 was sitting at the table doing a puzzle activity. CR1 stood at a position over R2 while talking "down" loudly instructing R2 to put things away and get ready for dinner. R2 responded by saying "yes", "yes". During an interview with the Registered Nurse (RN) on 07/29/21 at 12:15 PM, RN acknowledged that CR1 should not have been positioned over R2 while talking down loudly.	9 279	Correction: The caregiver and other staff were given re-training oh how to appropriately offer an active treatment to the clients. They were advised to talk to the clients with a soft voice instead of loud voice and when doing active treatment, they were advised to sit in-front and/or next to the clients. Future Plan: The QIDP will check the house and observe the active treatment at least 3 times a week to assist with the programming of the client. The QIDP will train the caregiver and reliever as necessary while at the house.	08/10/21