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 _____	01/21/2022

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

(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 State Agency (SA) from 01/19/22 through 01/21/22. The facility was found not to be in compliance with: Hawaii administrative rules, Title 11, Chapter 99, subchapter 9 Dietetic services (d)(2)(a) Hawaii administrative rules, Title 11, Chapter 99, subchapter 15 Infection Control (b) Survey dates: 01/19/22 through 01/21/22 Census: Four clients. Sample size: Two clients.	9 000	RECEIVED '22 FEB 14 P2:10 STATE OF HAWAII DOH-HCA MEDICARE CERTIFICATION	
9 091	11-99-9(d)(2)(A) DIETETIC SERVICES All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. This Statute is not met as evidenced by: Based on observations and interviews the facility failed to ensure proper infection control preventive measures were implemented as evidenced by a scooper being stored in a raw rice storage container. Findings include: On 01/19/22 at 02:30 PM, surveyor observed a closed plastic storage bin in the household kitchen. Raw rice and a clear plastic cup were inside of the plastic bin. Surveyor asked Direct Support Assistant (DAS) 2 if the plastic cup stays in the rice bin. DAS2 stated, "No, the plastic cup does not belong in the bin. We always remove it." DAS2 then opened the bin, removed the cup and placed it in the sink.	9 091	Home manager was counseled and advised to remove the plastic cup scooper out of the rice bin as soon as it was pointed out by the Surveyor. Staff was reminded not to leave the plastic cup in the rice bin. Systemic: Laminated label/sign was distributed to all ICF homes to be posted on the rice bin to remind staff not to leave the plastic scooper inside the rice bin. Plastic scooper also needs to be washed and air dried after each use and stored in a clean area. Infection Control training scheduled for 2/16/22 & 2/23/22 will also cover Food safety and handling. QA: Home manager to provide weekly oversight and assigned RN to complete quarterly checks to ensure compliance by staff.	1/21/22 1/28/22 on-going

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kaylee Dan	RN, ICF Program Manager	2/9/22

2/10/22 - Fax copy to CT ibn

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9 091	Continued From page 1 On 01/22/22 at 12:00 PM, Nurse Manager (NM) was interviewed. NM stated, "The scooper is not supposed to be in the rice bin because the rice can get contaminated. It is supposed to be cleaned and stored separately after being used. We have to remind staff about this."	9 091		
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, record reviews, and interviews, the facility failed to ensure proper infection control preventive measures were implemented as evidenced by positioning Client (C) 4's urine drainage catheter bag above C4's waist. As a result of this deficient practice, C4 was put at risk for urinary infections due to possible improper drainage of urine into her urine drainage catheter bag. Findings include: On 01/19/22 at 03:45 PM, surveyor observed C4 getting ready to use the bathroom. Direct Support Assistant (DAS) 1 and Direct Support Assistant (DAS) 2 transferred C4 from her wheelchair to the toilet. DAS2 then transferred C4's urine drainage catheter bag from under C4's chair, emptied the urine from the bag into the toilet, and then hanged the bag onto the side rail bar located on the wall next to the toilet. DAS 2 moved the wheelchair away from the toilet. The	9 151	Nurse Manager ordered hooks to be attached to the bathroom hand rail as soon as the Surveyor pointed out the deficiency. The hooks are now being used to ensure that the catheter bag is positioned lower than the client's waistline or shower chair/toilet seat to prevent back flow of urine. Systemic: Health Maintenance Plans on Risk for Urinary Infection secondary to use of catheter to be reviewed with the staff at the home. Special focus on proper placement of the urine drainage bag will be emphasized. All homes with client that uses catheter bags will be included in the review training to be accomplished by 2/15/22. Infection control In service training is scheduled for 2/16/22 &2/23/22. QA: Home manager will randomly check staff compliance. Assigned RN to do a monthly visit and observation to ensure compliance.	1/23/22 2/15/22 Monthly

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9 151	Continued From page 2 surveyor observed that C4's urine drainage catheter bag was hanging above C4's waistline and that urine inside the catheter tube was not flowing into the drainage bag. After C4 used the toilet, DAS1 removed C4's urine drainage catheter bag from the side rail and kept it below C4's waist level. DAS1 and DAS2 then transferred C4 to the shower chair. DAS1 then hanged C4's urine drainage catheter bag on the side rail located next to the shower chair. The surveyor observed that the urine drainage catheter bag was hanging above C4's waistline and that urine inside the catheter tube was not flowing into the drainage bag. DAS1 proceeded to give C4 a shower. On 01/19/22 at 4:00 PM, Home Manager (HM) entered the bathroom. Surveyor asked HM about the height of C4's urine drainage catheter bag on the side rail. HM stated, "Oh, the urine is backflowing. The bag is too high. It should be hung below the waistline. I will have to talk to management about this." DAS1 stated, "There is no place to hang C4's bag except the rail or else it will be on the ground where it's dirty." Surveyor then asked about hanging the urine drainage catheter bag on the side rail located near the toilet. HM stated, "That rail is too high also. I will address that with management too." On 01/22/22 at 10:30 AM, a review of C4's record was done. "Annual Nursing Notes for IPP Period covered: September 2020-September 2021" stated that C4 had a kidney transplant in 2008 and has a neurogenic bladder (urine is unable to release and hold urine at the right time). She has a urine ostomy (hole surgically created in the abdomen to redirect urine away from the bladder) and suprapubic catheter (hollow flexible tube inserted in urine ostomy) to help drain urine into a	9 151	This page intentionally left blank.	

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9 151	Continued From page 3 connected drainage bag. She was hospitalized in 10/21/20 and 05/05/21 for sepsis due to urinary tract infections. C4's "Health Maintenance Plan" dated 12/14/21 stated that C4 has a "Problem/need/concern: risk of urinary infection related to urinary ostomy and suprapubic catheter" with "Interventions: Check for kinks. Ensure that the drainage bag is positioned underneath the bed or chair. Reposition client as needed." On 01/22/22 at 12:00 PM, Nurse Manager (NM) was interviewed. NM confirmed that C4's "Health Maintenance Plan" dated 12/14/21, included interventions to position C4's drainage bag underneath the bed or chair. NM stated, "The urine bag should have been hanged lower than C4's waist. We are looking into installing something in the bathroom so we can hang C4's urine bag below her waist when she goes to the bathroom or takes a shower."	9 151	This page intentionally left blank.	