STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

(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) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance on February 18, 2022. The facility was found not to be insubstantial compliance with §42 CFR 483, Subpart B. Survey Dates: February 15, 2022 to February 18, 2022 Survey Census: 33 Sample Size: 13	F 000		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews (RR), the facility failed to ensure a medication error rate of less than 5%, as evidenced by three medication errors observed out of thirty opportunities for errors, for an error rate of 10%. Safe medication administration practices are essential for the health and well-being of the residents. As a result of this deficient practice, two residents received the wrong dose, and one resident was placed at an increased risk of medication side effects. This deficient practice has the potential to affect all residents in the facility. Findings include:	F 759		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

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F 759	Continued From page 1	F 759		

1) On 02/17/22 at 07:46 AM, observations were done with licensed practical nurse (LPN)1 in the dining room as she conducted her morning medication pass.

On 02/17/22 at 07:52 AM, LPN1 was observed administering medications to resident (R)1. One of the medications that was administered was one tablet of Vitamin C 500 milligrams (mg).

On 02/17/22 at 02:30 PM, while reconciling the medications administered to R1's medication administration record (MAR) and physician orders, it was noted that R1's ordered dosage for Vitamin C was two tablets (or 1000 mg).

On 02/17/22 at 02:36 PM, an interview was done with registered nurse (RN)1 at the nurses' station. RN1 confirmed that the order was increased from 500 mg to 1000 mg on 10/03/21. RN1 then validated that the blister pack for R1's Vitamin C in the medication cart was still displaying the old order. When asked why the MAR/physician order did not match the blister pack from the pharmacy, RN1 stated maybe the blister pack was old, she needed to look into the problem. It was noted at this time by the surveyor that the Vitamin C blister pack had a "received date" of 01/29/22. When asked about the process of placing an order, RN1 explained that the charge nurse was responsible to receive physician orders. For medication orders, the charge nurse would put the order into the electronic health record (EHR) and the order would immediately display on the MAR. Then the charge nurse was responsible to fax the order to the pharmacy, and verbally report off to the medication nurse any new medication orders received. No documentation of the verbal reports

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	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

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F 759	Continued From page 2	F 759		

were done; however, the fax confirmation records were kept to document that the order was sent to the pharmacy. RN1 was asked to produce the fax confirmation record for the Vitamin C order.

On 02/18/22 at 11:08 AM, when asked again for the fax confirmation record, RN1 reported that the facility no longer had the fax confirmation records from October 2021, stating, "I guess they throw them away after a while."

2) On 02/17/22 at 08:04 AM, LPN1 was observed in the dining room administering medications to R7. One of the medications that was administered was one tablet of Metoprolol 50 mg.

On 02/17/22 at 10:00 AM, while reconciling the medications administered to R7's with the MAR and physician orders, it was noted that R7's ordered dosage for the Metoprolol was 25 mg.

On 02/17/22 at 10:15 AM, an interview was done with LPN1 at the medication cart next to the nurses' station. LPN1 confirmed that the order reads 25 mg, and that she administered 50 mg. LPN1 stated the order was "changed last week." Record review noted the order was decreased from 50 mg to 25 mg on 02/04/22. LPN1 confirmed that there were two blister packs in the medication cart for R7 of the 50 mg tablets, and no blister packs of 25 mg tablets. There were no alert stickers observed on either blister pack to indicate that there had been a change in dosage.

On 02/17/22 at 10:24 AM, an interview was done with the Director of Nursing (DON) in the Family Room. The DON stated that there should have been an alert sticker placed on R7's existing blister pack(s) of the change in dosage at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

(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) COMPLETION DATE
F 759	Continued From page 3	F 759		

time that the order was entered to alert the medication nurses that the dosage had been changed. The DON also confirmed that the expectation is that the medication nurse verifies the medication name and ordered dosage on the MAR at the time he/she prepares any medication for administration.

3) On 02/17/22 at 08:06 AM, LPN1 was observed in the dining room preparing the following medications to administer to R4:

1. one tablet of Glipizide ER [extended release] 5 mg
2. one tablet of Stimulant Laxative Plus
3. one tablet of Clopidogrel 75 mg
4. one tablet of Metformin 500 mg
5. one capsule of Gabapentin 100 mg
6. one tablet of Clonazepam 0.5 mg
7. one measured dose of Polyethylene Glycol 17 gm mixed in half a cup of liquid

LPN1 was observed placing all of the tablets into one bag and crushing them together. When asked if it was OK to crush all of them, and to crush them together, LPN1 stated that is the way she was taught to prepare R4's medication when she was oriented to her position a couple months ago.

On 02/17/22 at 11:57 AM, during an interview with LPN1 at the medication cart next to the nurses' station, LPN1 confirmed that she crushed R4's Glipizide ER. Examined the blister pack for the Glipizide ER with LPN1 and noted that the blister pack had an alert sticker from the pharmacy that read "do not chew or crush." LPN1 stated she had never noticed the sticker before.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

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F 759	Continued From page 4 On 02/17/22 at 12:02 PM, an interview was done with the registered nurse (RN)2, who was the Charge Nurse at that time. RN2 confirmed that she trained LPN1 and told her it was OK to crush all R4's tablets together, including the Glipizide ER. RN2 stated that she was not aware that Glipizide ER should not be crushed and did not notice the alert sticker either.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

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F 761	Continued From page 5	F 761		

Based on observations, interviews, and record reviews, the facility failed to ensure all medications used in the facility were labeled in accordance with professional standards, including alert stickers and expiration dates. Proper labeling of medications is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility.

Findings include:

1) On 02/17/22 at 07:46 AM, observations were done with licensed practical nurse (LPN)1 in the dining room as she conducted her morning medication pass.

On 02/17/22 at 08:04 AM, LPN1 was observed administering medications to resident (R)7. One of the medications that was administered was one tablet of Metoprolol 50 mg.

On 02/17/22 at 10:00 AM, while reconciling the medications administered to R7's medication administration record (MAR) and physician orders, it was noted that R7's ordered dosage for the Metoprolol was 25 mg.

On 02/17/22 at 10:15 AM, an interview was done with LPN1 at the medication cart next to the nurses' station. LPN1 confirmed that the order reads 25 mg, and that she administered 50 mg. LPN1 also confirmed that there were two blister packs of Metoprolol in the medication cart for R7 of the 50 mg tablets, and no blister packs of the prescribed dosage, 25 mg tablets. There were no alert stickers observed on either blister pack to indicate that there had been a change in dosage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

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F 761	Continued From page 6 On 02/17/22 at 10:24 AM, an interview was done with the Director of Nursing (DON) in the Family Room. The DON confirmed that there should have been an alert sticker placed on R7's existing blister pack(s) at the time that the order was entered, to alert the medication nurses that the dosage had been changed. 2) On 02/17/22 at 08:30 AM, LPN1 was observed in the dining room preparing to administer medications to R27. One of the medications that she was preparing was R27's Lactulose Solution. LPN1 stated that although the dosage on the medication label on the bottle read "30 ml [milliliter]", she could see on R27's MAR that the dosage had been increased to 45 ml[s]. There were no pharmacy alert stickers observed on the bottle to indicate that there had been a change in dosage. LPN1 was asked if they had the new bottle with the correct dosage label on it, LPN1 responded that there was none in the cart. LPN1 was able to locate a new bottle with the correct dosage label in the medication room, which she then placed into the medication cart. LPN1 was not observed either removing the old bottle from the cart or placing a pharmacy alert sticker on it to indicate that the dosage had been changed. When asked what is normally done when there is a dosage change, LPN1 stated that she had not been taught that. 3) On 02/17/22 at 02:24 PM, an inspection of the day shift medication cart was done next to the nurses' station. In the top drawer of the cart, two insulin pens were found for two different residents. Both insulin pens were clearly labeled with pharmacy alert stickers with instructions to refrigerate until opened. Both insulin pens were	F 761		

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	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

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F 761	Continued From page 7 also clearly labeled with stickers requiring the user to fill in the date that the pen was opened, and the date that the pen should be discarded. Neither insulin pen had the labels filled in. On 02/17/22 at 03:19 PM, an interview was done with registered nurse (RN)1, who was the Charge Nurse at the time. When questioned about insulin pens, RN1 stated that if an insulin pen is in the cart, then it has been opened and it should have an opened date written on it. At 03:26 PM, RN1 stated that she had spoken to the day shift medication nurse who confirmed that she had opened and used both insulin pens the previous day and neglected to fill in the dates on the labels.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		

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	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

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F 812	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of the facility's policy and procedures, the facility did not assure food was stored in accordance with professional standards for food service safety. This deficient practice has the potential to result in contamination of food served to residents in the facility. Findings include: During an initial tour of the kitchen with the Line Cook (LC) on 02/15/22 at 07:45 AM, observed scoopers were stored in the flour and rice. The LC confirmed the scoopers are not to be stored in the flour and rice bins. At 08:05 AM, the Executive Chef (EC) continued the initial tour. Observations with the EC found bowls of salads that were not labeled with preparation date. EC stated stated the salads were made yesterday. Inquired how she knew they were made yesterday, she replied that the kitchen prepares salads everyday and if there are any leftovers, it is served to the employees. Observation of the walk-in refrigerator found four bottles of fat free milk with an expiration date of 02/13/22 and three bottles of 2% milk with an expiration date of 02/13/22. Also observed a metal container of cooked chicken with plastic wrap not fully covering the container. The EC reported it should be completely covered to prevent exposure from debris. Observation of the walk-in freezer found a pre-scooped bowl of chocolate ice cream that was not covered. Interview with the Food and Nutrition Manager	F 812		

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	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

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F 812	Continued From page 9 (FNM) was done on 02/17/22 at 03:29 PM. FNM stated their supplier takes away the expired milk, staff need to check the milk and return it to their supplier. FNM reported posting a sign for the supplier may help to ensure expired milk is not left in the refrigerator. Inquired with FNM about the partially covered cooked chicken and uncovered ice cream. FNM responded food items should have been looked at, tightly covered, and labeled to prevent debris from falling on the food, ensuring the sanitation quality of the food. Review of the facility's policy and procedures, "Food-Supply Storage - Food and Nutrition Services" dated on 06/23/21, "Foods that have been opened or prepared are placed in an enclosed container, dated, labeled and stored properly....Use by and Freeze by (expiration) dates are checked on a regular basis; foods/fluids that have expired or are otherwise unsafe for use are discarded."	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

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F 880	Continued From page 10 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 11 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff members and review of the facility's infection control policy, procedures, and protocols, the facility failed to ensure appropriate protective and preventive measures for COVID-19 and other communicable diseases and infections were implemented. The facility failed to: 1) Ensure staff members followed the facility's protocol for the use of personal protective equipment (PPE), hand sanitizing, and sanitizing of face shields while providing care to residents on transmission-based precautions (infection control precautions in health care settings applied for residents who are known or suspected to be infected or colonized with infectious agents, requiring additional control measures to effectively prevent transmission); 2) Ensure staff members sanitized shared equipment (blood pressure cuff) between residents; and 3) Ensure proper storage of gloves and staff	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

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F 880	Continued From page 12	F 880		

member performed hand sanitizing before applying gloves.

These deficient practices placed all residents, and facility staff at risk for contracting infections, including COVID-19. These failures had the potential to negatively impact the residents, entire facility staff, and community, with possibility of resulting in harm, serious injury, or death.

Findings include:

1) On 02/15/22 at 08:10 AM, during a tour of the facility, it was noted that the residents in room 20 and room 22 had been placed on transmission-based precautions (TBP) due to their new admission status. Clear signage posted outside both rooms stated the following:

"STOP
PROTOCOL
EVERYONE MUST:
CLEAN THEIR HANDS, INCLUDING BEFORE AND WHEN LEAVING THE ROOM
PUT ON A GOWN BEFORE ENTERING THE ROOM. DISCARD OR HANG UP GOWN BEFORE EXITING ROOM ..."

Clear signage posted inside of both rooms, near the exit, stated the following:

"All staff must wear Face shield protection as well as surgical mask for all direct resident care ...When exiting ...staff must clean their face shield each time with Purple top wipe."

On 02/15/22 at 08:20 AM, an observation was done of certified nurse aide (CNA)2 entering room 22 without performing hand hygiene prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

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F 880	Continued From page 13	F 880		

entrance. CNA2 took the resident's vital signs (blood pressure, temperature, heart rate, respirations, and oxygen saturation), utilizing an automated vital signs machine, performed some personal tasks for the resident, discarded her personal protective equipment (PPE), washed her hands, then exited the room where she was seen entering room 21 with the vital signs machine. It was noted that there were no cleaning wipes on the cart housing the vital signs machine, and CNA2 was not observed cleaning the blood pressure cuff on the machine or her face shield prior to moving on to the next room.

On 02/15/22 at 08:25 AM, CNA2 was observed entering room 20 without performing hand hygiene. CNA2 wheeled the vital signs machine into the room with her. When she exited the room at 08:30 AM, CNA2 did not clean the blood pressure cuff, nor did she clean her face shield. When asked about not performing hand hygiene prior to entering the TBP rooms, despite the presence of alcohol-based hand rub (ABHR) dispensers at both entrances, CNA2 stated that she had washed her hands prior to exiting the previous room. Surveyor pointed out that signage posted at both entrances instructed staff to perform hand hygiene at entrance and exit. CNA2 responded by acknowledging that she did not follow the posted protocol, however she stated that she had a "medical reason" for it, explaining that the ABHR dried her hands out too much. When questioned about not cleaning the blood pressure cuff on the vital signs machine, CNA2 confirmed that she should clean it after every resident.

On 02/15/22 at 08:33 AM, an observation was made of CNA1 entering room 22 without donning

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	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY AND JEANETTE WEINBERG CARE CENTER	45-090 NAMOKU ST KANEOHE, HI 96744

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F 880	Continued From page 14	F 880		

a gown. The Infection Preventionist (IP) walked up to the room just as CNA1 was exiting, and she reminded CNA1 that she should be donning a gown for the TBP rooms, pointing to the signage posted at the door as she spoke.

On 02/15/22 at 08:34 AM, an interview was done with the IP as she stood outside of room 22. The IP stated that her expectation is that staff who see TBP signage outside and inside rooms, follow the instructions posted. For rooms 20 and 22, the IP confirmed she expected staff to perform hand hygiene at entrance and exit, and before and after using gloves, and that they should be donning a gown. The IP also confirmed that staff should be cleaning reusable equipment between each resident with a "purple wipe," and that each machine should have a container of wipes within its housing cart. When questioned about staff with exemptions for using ABHR, the IP stated that she was not aware of any staff with either skin or medical conditions that would prevent them from using ABHR.

On 02/15/22 at 12:51 PM, an observation was made of CNA4 and Minimum Data Set Coordinator (MDSC) exiting room 22 without cleaning their face shields.

On 02/18/22 at 09:57 AM, an interview was done with the IP in the Conference Room. When asked about the signage inside the TBP rooms instructing staff to clean their face shields at exit, the IP confirmed that the signage should be posted in the new admission rooms, and that staff should be following those instructions. The IP also acknowledged that through performing/reviewing weekly PPE audits on staff, she had identified problems with inconsistent

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	125033	A. BUILDING _____ B. WING _____	02/18/2022

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F 880	Continued From page 15	F 880		

hand hygiene and not cleaning face shields.

On 02/18/22 at 11:00 AM, while reviewing the Care Center COVID Guidance for Admissions & Outings, last revised on 11/21/21, the following was noted:

"Quarantine: All newly admitted residents, despite vaccination status, will be quarantined upon admission ...Fully Vaccinated Resident: shall be placed in the New Admission Area in a room by him/herself for 5 days following admission ..."

2) On 02/15/22 at 09:43 AM observed CNA1 preparing to take Resident (R)4's blood pressure. CNA1 was wearing gloves while wiping down blood pressure cuff. CNA1 removed her gloves, washed her hands at the sink, and proceeded to take R4's blood pressure. After taking the resident's blood pressure, CNA1 removed gloves from her pocket, dropped a glove on the floor which was picked up and thrown away, then got another glove from her pocket. CNA1 applied the gloves to both hands, wiped down the blood pressure cuff and machine. CNA1 then removed her gloves and washed her hands.

On 02/17/22 at 12:15 PM an interview was conducted with the Infection Control Preventionist (IP). The observation of 02/15/22 at 09:43 AM was shared with the IP. The IP acknowledged infection control breeches occurred. The IP reported the facility has boxes of gloves available to staff and confirmed gloves are not to be stored in pockets. Also, the IP confirmed staff members are to perform hand hygiene before applying gloves. The IP stated that staff are reminded to perform hand hygiene at all times and if you are not sure whether it is needed, perform hand hygiene.

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F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 883		

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	125033	A. BUILDING _____ B. WING _____	02/18/2022

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F 883	Continued From page 17	F 883		

medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on interview and record reviews (RR), the facility failed to ensure two of five residents sampled were offered or received the pneumococcal vaccine. Coupled with advanced age and chronic conditions, this deficient practice made residents vulnerable to the bacteria that causes pneumonia. This deficient practice has the potential to affect all residents at the facility.

Findings include:

On 02/16/22 at 12:04 PM, during a review of immunization records for residents, it was noted that resident (R)28 and R29 both did not have their pneumococcal vaccination status documented in their electronic health records (EHR). Upon further review of their EHR(s), no documentation was found that either resident had been offered and/or refused a pneumococcal vaccine.

On 02/18/22 at 09:57 AM, an interview was done

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F 883	Continued From page 18	F 883		

with the Infection Preventionist (IP) in the Conference Room. The IP stated that following up on all resident immunizations are her responsibility. After confirming that R28 and R29 were missing their pneumococcal vaccination status, the IP stated she would review their records more closely to find out what happened. The IP acknowledged that she should have noticed and followed up on their vaccination status earlier, stating, "I missed it."

On 02/18/22 at 10:30 AM, during a review of the facility's policy and procedure, Immunizations for Residents - Infection Control, issued June 2012, and last revised on 12/01/19, the following was noted:

"Upon admission, each resident and/or resident representative will receive the Vaccination Information Statements (VIS) for influenza and pneumococcal vaccines ... If the resident and/or the resident representative consent to vaccinations for pneumococcal ... Obtain written consent ... If the resident and/or resident representative chooses not to be vaccinated, select Refused ..."

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	125033	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) from 02/15/22 through 02/18/22. The facility was found to be in substantial compliance with Appendix Z, Emergency Preparedness, §42 CFR 483.73 for Long Term Care facilities	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	125033	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/17/2022**

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HARRY AND JEANETTE WEINBERG CARE CENTER	**45-090 NAMOKU ST** **KANEOHE, HI 96744**

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K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: K-761 Maintenance, Inspection and testing-Doors This STANDARD is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for an annual inspection for the fire doors in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, sections 5.2, and 5.2.3. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of an annual inspection to ensure proper protection from fire and smoke extension within the facility. Findings include: During record review on 2/17/22 at approximately 12:30 pm revealed that the facility failed to provide documentation for the annual fire door inspection. These findings were verified at the exit conference with the facility manager and Administrator on 2/17/22 at 2:15 pm.	K 761		

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K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: K-918 Electrical Systems-Essential Electric	K 918	Past noncompliance: no plan of	

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	125033	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/17/2022**

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K 918	Continued From page 2 System Maintenance and Testing This STANDARD is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for an annual testing of diesel fuel in accordance with NFPA 99 Healthcare Facilities Code, 2012 edition, section 6.5.4, and NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition, section 8.3.8. This deficiency could affect all residents, staff, and visitors during an interruption of grid power due to the lack of an annual diesel fuel test to ensure proper operation of the standby power system. Findings include: During record review on 2/17/22 at approximately 12:15 pm revealed that the facility failed to provide documentation for the annual diesel fuel test. These findings were verified at the exit conference with the facility manager and Administrator on 2/17/21 at 2:15 pm.	K 918	correction required.	

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	125033	A. BUILDING _____ B. WING _____	02/17/2022

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E 000	Initial Comments THIS FACILITY MET THE LIFE SAFETY REQUIREMENTS OF APPENDIX "Z"; IN ACCORDANCE WITH CFR 483.73, REQUIREMENT FOR LONG-TERM CARE (LTC) FACILITIES	E 000		

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