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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

(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
4 000	Initial Comments A re-licensure survey was conducted by the Office of Health Care Assurance on February 18, 2022. The facility was found not to meet the requirements of the Hawaii Administrative Rules, Title 11, Chapter 94.1, Nursing Facilities.	4 000		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute 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.	4 159	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not insubstantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual.	3/31/22

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4 159	Continued From page 1 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 (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	4 159	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? No residents were identified as having been affected, but corrective action was taken to remedy the items identified: 1)On 2/15/22, the scoopers found in the flour and rice bins were immediately removed by the cook. 2)On 2/15/22, the bowls of salads not labeled with preparation date were discarded by the executive chef. 3)On 2/15/22, the (7) bottles of milk were immediately separated, labeled to say do not use / to be picked up by Meadow Gold. Meadow Gold picked-up the expired milk on Thursday. 4)The covering for the cooked chicken was immediately replaced. 5)The pre-scooped bowl of ice cream was immediately discarded by Executive Chef. HOW WILL OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, BE IDENTIFIED? On 2/15/22, the Executive Chef immediately conducted rounds to assure that no scoopers were stored in food bins, prepared foods were both covered and properly labeled with preparation date, and that there were no other bottles of expired milk. WHAT MEASURES WILL BE PUT INTO PLACE, OR WHAT SYSTEMIC CHANGES WILL BE MADE, TO ENSURE	

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4 159	Continued From page 2 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."	4 159	THAT THE DEFICIENT PRACTICE DOES NOT RECUR? The Food Service & Sanitation Worksheet was modified to include the need to check that prepared foods are properly covered and labeled, that expired milk is labeled and segregated, and that no scoopers are in food bins. On 2/15/22, the Director of Food and Nutrition Services provided education to dietary staff members regarding proper placement of food scoopers, the need to ensure that prepared foods are covered and labeled with preparation date, and the process to separate and label expired milk for return to the vendor. HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR? On 3/8/22, a focus audit was developed to monitor and ensure that food scoopers are properly stored, foods are properly covered and labeled, and expired milk is properly labeled and segregated for vendor pick-up. This focus audit will be conducted by the Director of Food and Nutrition Services or designee weekly for 4 weeks, monthly for 2 months and quarterly for 3 quarters. This audit will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified	

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4 159	Continued From page 3	4 159	opportunities for improvement.	
4 192	11-94.1-46(i) Pharmaceutical services (i) Appropriately licensed and trained staff shall be responsible for the entire act of medication administration, which entails removing an individual dose from a container properly labeled by a pharmacist or manufacturer (unit dose included), verifying the dosage with the physician's orders, giving the specified dose to the proper resident, and promptly recording the time, route, and dose given to the resident, and signing the record. Only a licensed nurse, physician, or other individual to whom the licensed professional has delegated the responsibility pursuant to chapter 16-89, subchapter 15, may administer medications. This Statute is not met as evidenced by: 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.	4 192	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? 1)On 2/17/22, a large, bold ALERT! Change in Order sticker was placed on (R)7□s blister pack of Metoprolol. On the same day, a new blister pack with the correct dose of (R)7□s Metoprolol was obtained. 2)On 2/17/22, a large, bold ALERT! Change in Order sticker was placed on (R)27□s bottle of Lactulose. On the same day, the Lactulose bottle was replaced with a Lactulose bottle reflecting the	3/31/22

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4 192	Continued From page 4 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. 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	4 192	correct order. 3)On 2/17/22, the insulin pens were replaced and properly labeled with the date the pen was opened. HOW WILL OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, BE IDENTIFIED? All residents have the potential to be affected by this deficient practice. On 3/10/22, the current medication orders in the EHR for all residents were compared with the correlating medication blister packs and blister packs reviewed for the presence of Alert! Change in Order stickers applied, when indicated. Any discrepancies were immediately corrected. On 3/10/22, labels for opened medications were reviewed to ensure that they were all properly dated. Any discrepancies were immediately corrected. WHAT MEASURES WILL BE PUT INTO PLACE, OR WHAT SYSTEMIC CHANGES WILL BE MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? All licensed nurses will be re-educated on: -Applying the new large, bold Alert! Change in Order stickers to medication blister packs to provider greater visible notification to licensed nurses when there has been an order change. -The new process of stapling the fax confirmation sheet to the new order when	

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4 192	Continued From page 5 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 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.	4 192	a changed order is faxed to pharmacy. -The importance of ensuring that the order on the medication blister pack matches the order in the EHR. -The night nurse□s responsibility to daily reconcile new orders (from the past 24 hours) in the EHR with the corresponding medication blister pack. -The need to properly label medications with the open date when indicated. This re-education will be provided by DNS or designee on 3/17/22 or prior to licensed nurses next schedule shift. HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR? On 3/10/22, a focus audit was developed to monitor and ensure compliance. The focus audit addresses the following items: The label on medication blister packs match changed orders, (when indicated) the bold alert sticker is adhered to the medication blister packs, a fax confirmation sheet is stapled to changed medication orders, and (when indicated) medications are properly labeled with the open date. This focus audit will be conducted by the Director of Nursing or designee weekly for 4 weeks, monthly for 2 months and quarterly for 3 quarters. This audit will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations	

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4 192	Continued From page 6	4 192	as needed. The Quality Assurance Committee will use the Model of Improvement for any identified opportunities for improvement.	
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute 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	4 203	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE? On 2/15/22, DON provided re-education to CNA#2 on the importance of performing hand hygiene upon entering and prior to leaving each resident□s room. On 2/17/22, the Infection Control Preventionist provided re-education to staff, including CNA#2, on importance of disinfecting the blood pressure cuff on the vital sign machine between each resident use and sanitizing their face shields when exiting a room with TBP. On 2/17/22, the Infection Control Preventionist ensured that each vital sign machine had the appropriate container of sanitizer placed in the housing basket for	4/15/22

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4 203	Continued From page 7 3) Ensure proper storage of gloves and staff 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	4 203	proper disinfecting between each use. On 2/17/22, the Infection Control Preventionist provided re-education to CNA#1 on the importance of proper PPE use. Especially on the need to don a gown prior to entering a room with TBP. On 2/17/22, the Infection Control Preventionist provided re-education to the MDS Coordinator on the importance of disinfecting his face shield when exiting a room with TBP. On 2/17/22, the Infection Control Preventionist provided re-education to the CNAs, including CNA#1, on proper hand hygiene and the importance of proper storing of PPE □ especially the storing of gloves which are not to be kept in pockets. HOW WILL OTHER RESIDENTS, HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE, BE IDENTIFIED? All residents have the potential to be affected by this practice. WHAT MEASURES WILL BE PUT INTO PLACE, OR WHAT SYSTEMIC CHANGES WILL BE MADE, TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? All staff will view the below training videos: -Clean Hands https://youtu.be/xmYMUly7qiE -Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw -Use Personal Protective Equipment Correctly for COVID-19	

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4 203	Continued From page 8 room 22 without performing hand hygiene prior to 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	4 203	https://youtu.be/YYTATw9yav4 The online infection prevention training courses below and found at https://www.train.org/cdctrain/training_plan/3814 and referenced in QSO 19-10 NH dated 03/11/2019 will as well be utilized to educate and train staff: -Module 6A (Principles of Standard Precaution) -Module 6B (Principles of Transmission-Based Precaution) Training on this material will be provided by the Director of Nursing or Infection Preventionist. The related training documents (and related attendance sheets) will be submitted to OHCA. A root cause analysis will be completed by facility leadership with GSS corporate leadership support. The root cause analysis will be presented to Quality Assurance Committee for review and further recommendations. HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR? On 3/8/22, a focus audit was developed to ensure infection control policy and procedure compliance. Audit includes observing employees hand hygiene, cleaning of equipment between residents, and proper glove storage and use. Any deficient practices will be immediately addressed.	

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4 203	Continued From page 9 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 hand hygiene and not cleaning face shields.	4 203	This focus audit will be conducted by the Infection Prevention Nurse or designee daily for 5 days, weekly for 3 weeks, monthly for 2 months and quarterly for 3 quarters. This audit will be reviewed by the Quality Assurance Committee monthly for compliance, trends and recommendations as needed. The Quality Assurance Committee will use the Model for Improvement for any identified opportunities for improvement.	

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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) COMPLETE DATE
4 203	Continued From page 10 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.	4 203		