STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	A. BUILDING _____ B. WING _____	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY 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 COVID-19 Focused Infection Control Survey was conducted by the Office of Health Care Assurance (OHCA) on May 25, 2022. The facility was found not to be in substantial compliance with 42 CFR §483.80 infection control regulations and has not complied with implementing the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to properly prevent and/or control the transmission of COVID-19. Survey Census: 84	F 000		
F 880 SS=E	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 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	F 880		7/9/22

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

Electronically Signed | 07/01/2022

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F 880	Continued From page 1 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. §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.	F 880		

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F 880	Continued From page 2 §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 observation, interview, and record review, in response to a COVID-19 outbreak (one positive direct-care staff member) identified on 04/12/22, the facility failed to ensure appropriate protective and preventive measures for COVID-19 were executed, as evidenced by the facility failing to follow and implement their infection prevention and control policies and procedures, including the transmission-based precautions of their COVID-19 Plan to control and prevent the spread of COVID-19. Failure to follow the facility policies and CDC recommendations related to COVID-19 had the potential to contribute to the transmission and spread of COVID-19 in the facility's vulnerable population. As a result of this deficient practice, staff and patient safety was compromised. Findings include: On 05/25/22 at 08:30 AM, an interview was done with the Infection Preventionist (IP) in the Education Conference Room. The IP stated that the facility had an ongoing COVID-19 outbreak which began on 04/12/22, with the identification of a direct-care staff member who tested positive. When asked about resident deaths during the current outbreak, the IP stated that two of their residents had passed away. At the time of survey entrance, the facility had two residents (R) remaining on isolation after testing positive on 05/17/22. When asked about the facility's COVID-19 isolation practice and staff	F 880	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #3 and Resident #4 remained in isolation with Transmission Based Precaution in place. 2. Address how the facility will identify other residents having potential to be affected by the same deficient practice. All alleged practice has the potential to affect all residents in the facility. 3. What measures will be put into place or	

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F 880	Continued From page 3 assignment, the IP stated that on 05/25/22, the two remaining positive residents (R3 and R4) were isolated together in one "Red Room [Room 204]," and assigned to Registered Nurse (RN)1, and Certified Nurse Aide (CNA)1, with CNA2 covering when CNA1 was on break or unavailable. The IP confirmed that in addition to the COVID-positive residents, RN1 was assigned to the remaining residents on the wing that contained Room 204, and CNA1 was assigned to one resident in Room 203 and 207, plus both residents in Room 206. Room 203 housed a second resident who was assigned to CNA3. On 05/25/22 at 11:49 AM, an observation was done of CNA1 Tina exiting Room 204 with bagged trash from the room in doubled clear bags. CNA1 doffed her PPE and placed it into the trash can outside the door. The trash can was too full for the bagged trash she had carried out of the room, so CNA1 carried the bagged trash down the hall to the dirty utility room to discard it. At 11:55 AM, while standing outside the second-floor elevator, the IP stated that bagged trash from Room 204 should be in yellow bags, and picked up by Housekeeping, not carried down the hallway. On 05/25/22 at 03:06 PM, during an interview with the IP in the Financial Office Conference Room, the IP confirmed that there was no dedicated equipment in Room 204 for the COVID-positive residents. The IP also confirmed that the facility was no longer in crisis staffing. When discussing CDC recommendations and transmission-based precautions for COVID-19, the IP acknowledged and agreed that the facility should have dedicated equipment and staff for the COVID-positive residents.	F 880	what systemic changes will you make to ensure that the deficient practice does not recur? a. The facility Infection Control Preventionist or designee will review Facility Infection Control Program regarding protocol for Transmission-Based Precaution and update as indicated. b. The facility Infection Control Preventionist or designee will provide facility-wide in-service training on Standard Precautions and Transmission-Based Precaution. Training will include post-test to determine understanding. c. The facility will in-service direct care staff and housekeeping staff with proper disposal of trash for residents that are placed under Transmission-based precaution. d. The Infection Control Preventionist or designee will conduct a RCA and develop a checklist to be used to validate compliance with Facility□s Transmission Based Precaution Protocol. 4. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the correction action evaluated for its	

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F 880	Continued From page 4 During a review of the facility's Infection Prevention and Control Program Policy, revised on 01/08/21, the following was noted: "7. When transmission-based precautions are implemented: ... d. Disposable or dedicated, non-critical care items will be used for the resident."	F 880	effectiveness. The plan of correction is integrated into the quality assurance system. a. The Director of Nursing or designee will complete random audits of all Transmission based Precaution residents to validate compliance with facility IFC Transmission Based Precaution protocol/policy at least monthly. Results of the audits will be reviewed by the Quality Assurance Performance Improvement Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination	F 887		7/9/22

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F 887	Continued From page 5	F 887		

requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC]
and
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for

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F 887	Continued From page 6 Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to implement their COVID-19 vaccination policy for two residents in the sample. Specifically, the facility failed to document that the residents were provided education on the COVID-19 vaccine, were offered the vaccine, and/or refused the vaccine. As a result of this deficient practice, these residents were placed at an increased risk of suffering serious illness if infected with the COVID-19 virus. Findings include: On 05/25/22 at 08:30 AM, an interview was done with the Infection Preventionist (IP) in the Education Conference Room. The IP stated that the facility had an ongoing COVID-19 outbreak which began on 04/12/22, with the identification of a direct-care staff member who tested positive. When asked about resident deaths during the current outbreak, the IP stated that two of their residents had passed away, with one resident (R) receiving his first COVID-19 vaccination the day before testing positive, and the other resident (R1) remaining unvaccinated until death. On 05/25/22 at 10:30 AM, during a review of R1's electronic health record (EHR) for COVID-19 vaccination status, no documentation was found regarding whether the vaccine had been offered and/or refused. At 10:40 AM during a review of R2's EHR, no documentation was found regarding whether the COVID-19 vaccine had been offered and/or refused.	F 887	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who drafted or may be discussed in this response and Plan of Correction. This response and Plan of Correction is submitted as the facility□s credible allegation of compliance. 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident R1 discharged Resident R2 discharged 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The alleged practice has the potential to affect all facility residents. To identify other residents having the potential to be affected by the identified deficient practice, the facility has created a COVID-19 Immunization Tracking Tool. Facility wide audit on resident vaccination status was completed. Identified resident	

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F 887	Continued From page 7 On 05/25/22 at 04:21 PM, during an interview with the IP in the Financial Office Conference Room, the IP confirmed that she could find no documentation that R1 or R2 had been offered and/or refused the COVID-19 vaccine. During a review of the facility's COVID-19 Vaccination Policy, revised on 03/25/22, the following was noted: "2. COVID-19 vaccinations will be offered ...unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine." "9. The resident's medical record will include the documentation that the resident ...was provided education regarding the benefits and potential side effects ...that the resident received or did not receive the immunization due to medical contraindication or refusal ..."	F 887	who were not up-to-date and eligible for vaccination, the facility contacted resident/resident representative to provide education and obtain consent/declination preference. Nurse designee documents in resident electronic medical record. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? All not up-to-date residents will be offered COVID-19 vaccination upon admissions and/or upon eligibility. Vaccination education will be provided to resident and/or residents representative. COVID consent/decline form will be completed by resident/responsible party or by nurse upon verbal consent. Nursing will document in resident electronic medical record vaccination consent/declination preference and verify that vaccination education was provided. Facility will continue to coordinate with pharmacy provider to administer immunization. Resident COVID-19 immunization in-services conducted with the interdisciplinary team, admissions team, medical records, social services and licensed staff. Training will be ongoing and as needed. 4) Indicate how the facility plans to	

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monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.

Infection Preventionist or designee will audit resident records for:
a. COVID-19 vaccination status
b. resident□s eligibility to receive COVID-19 immunization
c. documentation of COVID-19 immunization consent/declination and vaccination education

Completion of audits to occur weekly x 1 month, bimonthly x 1 month and monthly x 1 month for a minimum of 12 weeks to ensure compliance.

Corrective action is to be taken immediately and staff education is to be provided as deemed necessary.

To ensure compliance, audit results will be reviewed, presented, and discussed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for a minimum of 3 months or until compliance is achieved.

If further corrective action is needed, the auditing will continue until such time that the QAPI committee determines consistent substantial compliance has been met.

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F 887	Continued From page 9	F 887	Results of the monthly QAPI meeting will be brought to the attention of the quarterly QA Committee meetings and addressed as deemed appropriate.	