STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12G029	A. BUILDING: _____ B. WING _____	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARC IN HAWAII - KAIMUKI A	3705 MAHINA AVENUE HONOLULU, HI 96816

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9 000	INITIAL COMMENTS A relicensure survey was conducted by the office of Health Care Assurance from January 18, 2022 through January 20, 2022. The facility was found not to be in compliance with the program requirements for Title 11, Department of Health, Chapter 99. The census at the time of entrance was three clients.	9 000		
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, review of the facility's policy and procedure and interview with staff members the facility failed to eliminate opportunities for cross-contamination of infections by ensuring staff remove and wash the cup to scoop rice in the rice storage container after use and ensure prepared hot food was stored at an appropriate temperature to inhibit bacterial growth. Findings include: 1) On 01/18/22 at 03:25 PM observed Home Staff (HS) 1 use a clear measuring cup to scoop rice into a rice pot. At 03:35 PM observed the same clear measuring cup in the rice storage container. Inquired with Home Manager (HM) about the cup stored in the rice storage container, HM stated it is normally not stored there and proceeded to ask HS1 to remove the cup and wash it. Interview with Nurse Manager (NM) and ICF Case Manager (ICF-CM) on 01/20/22 at 09:14	9 091		

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9 091	Continued From page 1 AM in the conference room, NM and ICF-CM concurred the cup to scoop rice should be stored separate to prevent contamination. 2) During an observation of the kitchen on 01/18/22 at 02:40 PM, observed a large, covered pot on the stove. The stove was off. At 03:23 PM, inquired with Home Staff (HS) 1 what was for dinner, HS1 proceeded to open the covered pot and stated pork adobo. At 03:57 PM, observed HS1 scoop the pork from the pot into a blender container filled with rice and blended the pork and rice together. This surveyor felt the base of the pot of pork adobo which felt room temperature. Surveyor inquired on the temperature of the pork, HS1 did not respond. The Home Manager (HM) took the thermometer out of a drawer and attempted to take the temperature of the pork. HM stated the thermometer was broken. After running the same thermometer through water in the sink, HM further stated the "dial was off ...", the thermometer was not broken and that the cooked pork was too cold for the thermometer to pick up the temperature. HM stated after cooking dinner early he turned off the stove but should have reheated the food. Review of the facility's policy and procedure on infection control dated on 07/29/21, states "Serve food soon after cooking or refrigerate immediately. Avoid keeping cooked foods at room temperature for a long time ...Refrigeration ...retards bacterial growth ..." Interview with Nurse Manager (NM) and ICF Case Manager (ICF-CM) on 01/20/22 at 09:14 AM in the conference room, NM stated cooked food should not be left out, in room temperature, for more than an hour. NM and ICF-CM both concurred this would prevent bacterial growth.	9 091		

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9 113	11-99-11(d) RESIDENT DAILY LIVING CARE AND TRAINING Restraints shall be used only under a physician's orders for specified and limited periods of time and so documented and shall be used only when resident in imminently dangerous to self or others. This Statute is not met as evidenced by: Based on observations, record review, and interview with staff members, the facility did not ensure Client (C)2 was free from the use of a physical restraint. A physical restraint is defined as any manual hold or mechanical device that the client cannot remove easily, and which restricts the free movement of, normal functioning, or normal access to a portion or portions of their body. Observations found Client (C)2 with black straps affixed across his chest, limiting his freedom of movement. Findings include: On 01/18/22 at 02:31 PM observed Home Staff (HS)1 wheel Client (C)2 into the living room. HS1 applied a wide black belt across C2's chest which was affixed with Velcro. The Home Manager (HM) instructed HS1 to remove the belt. Upon removal of the belt, C2 was observed with a chest strap (black straps that are attached to each side of the client's wheelchair and secured with Velcro). During the observation period from 02:31 PM through 06:15 PM, C2 was observed with the chest strap secured around his chest without release. C2 engaged in activities at home, he was seated in the living room with an overbed tray placed in front of him with activities (sensory board, ring stacking), ate dinner at 04:15 PM, and took medication at 06:10 PM.	9 113		

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9 113	Continued From page 3 On 01/19/22 at 08:30 AM, observed C2 at the day program, the chest straps were not affixed across his chest, the black wide belt was hanging on the back of his wheelchair. At 08:38 AM interviewed Day Program Staff (DPS)2 in the classroom regarding the use of the chest strap. DPS2 reported C2 does not wear the black strap when he is at program and it is applied when he is at home. At 08:45 AM the Assistant Center Manager (ACM) was interviewed in the classroom. ACM understands C2 wears the strap during transportation to prevent him from going forward during the ride. On 01/20/22 a review of the client's record found no documentation for the use of any device (chest straps) for C2. There was no physician order, consent for use, or an individual program plan to address the use of the chest strap. On 01/20/22 at 09:03 AM an interview was conducted with the ICF Case Manager (ICF-CM). ICF-CM reported the straps are removed when C2 is in program. Inquired whether the use of the chest strap was included in the client's individual program plan. ICF-CM could not recall whether it was included, however, recalled the use of the chest strap is discussed during the facility's monthly meetings. ICF-CM stated the nurses usually address the use of adaptive equipment. On 01/20/22 at 09:08 AM, the Nurse Manager (NM) joined the interview with ICF-CM. NM reported the chest strap is used for the client's safety during transportation in the van as there was an incident of C2 removing the seatbelt in the van. NM reported the chest strap is not required for positioning. Inquired whether C2 can remove the strap, NM replied C2 may be able to remove the strap sometimes but not when it is	9 113		

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9 113	Continued From page 4 secured in the back. Further queried whether the use of the straps was discussed in their committee to review whether the chest strap is a restraint for C2. NM responded she doesn't think it was presented to the committee. NM leafed through C2's chart and stated she was unable to find documentation the use of the chest strap was discussed with the committee. NM further reported the straps are not used at the program to release the pressure and have a little freedom in movement. NM was informed the use of the straps was observed in the home. NM replied if a staff member is with C2, the straps should be removed and reiterated the straps are for safety, not positioning.	9 113		
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 observation, record review, and interview with staff members, the facility did not assure control and prevention of infections for Client (C)2. The nursing staff did not ensure proper cleaning of C2's reusable tubing and catheter bag and ensure staff members washed their hands before and after disposable glove use while providing services to C2. Findings include: 1) On 01/18/22 observed C2 at home without a condom catheter. At 04:07 PM the Home	9 151		

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9 151	Continued From page 5 Manager (HM) was interviewed in the clients' home regarding the condom catheter. HM reported the condom catheter is removed when the client comes home and then reapplied at night. Inquired how the catheter tubing and bag is cleaned. HM responded the catheter bag is emptied, the tubing and catheter bag is rinsed and washed with dishwashing liquid. On 01/19/22 at 02:26 PM, the Nurse Manager (NM) and RN Case Manager (RN-CM) and was interviewed in the facility's conference room. NM reported the catheter tubing and bag can be re-used if it is not soiled. Further queried how is the catheter tubing and bag cleaned for re-use. NM responded items should be cleaned with a mixture of vinegar and water. Review of the Health Maintenance Plan dated 06/16/21 documents the proper Foley catheter care which has since been discontinued on 06/02/21 which instructs to "clean urine bag with soap and water at lease once a week if it's being reused". This plan was reviewed with the NM on 01/20/22 at 09:08 AM. Upon review, the NM commented the plan needs to be updated. 2) During an observation at Day Program on 01/18/22 at 12:00 PM, Day Program Staff (DPS) 1 stood up when providing C2 assistance with lunch, DPS1 threw worn disposable gloves in the trash can and retrieved new gloves without handwashing or hand sanitizing before putting on a new pair of gloves. Hand sanitizer was observed to be on the opposite side of the room from the box of disposable gloves. On 01/20/22 at 11:15 AM observed at the Day Program, DPS2 put on size small disposable gloves and assisted C2 with lunch. The left glove	9 151		

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9 151	Continued From page 6 worn by DPS2 had a tear between the ring and middle finger. After discussion between DPS2, Assistant Center Manager (ACM), and surveyors on the size of the gloves, ACM grabbed a box of size medium gloves from another room and offered DPS2 to use bigger gloves. DPS2 removed the small gloves with the tear and put on the size medium gloves without handwashing or hand sanitizing. Interview with Nurse Manager (NM) and ICF Case Manager (ICF-CM) on 01/20/22 at 09:14 AM in the conference room, NM stated staff should wash their hands before putting on disposable gloves and after taking the gloves off. NM further stated, " ...hands should be clean in case the gloves rip..." Review of the facility's policy and procedures on infection control dated on 07/29/21, instructs staff to "Wash hands after each use of gloves."	9 151		
9 154	11-99-16(a)(3) IN-SERVICE EDUCATION There shall be a staff in-service education program that includes: In-service training shall include annually: Prevention and control of infections, fire prevention and safety, accident prevention, resident's rights, and problems and needs of the mentally retarded. This Statute is not met as evidenced by: Based on review of the facility's documentation of in-service training for staff, the facility did not assure 1 of 4 employees completed annual training for infection control.	9 154		

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9 154	Continued From page 7 Findings include: On 01/19/21 at 08:31 AM concurrent review of the spread sheet of the staff member's completion of annual training was done with the Training Coordinator/Advocate (TC/A). The TC/A confirmed a staff member did not complete an annual training for infection control.	9 154		
9 189	11-99-22(c) PHARMACEUTICAL SERVICES Each drug shall be rechecked and identified immediately prior to administration. This Statute is not met as evidenced by: Based on review of incident reports and interview with staff members, the facility failed to ensure all drugs were administered in compliance with the physician's order for 1 of 2 clients in the sample. Findings include: A review of an incident report for Client (C)2 found documentation that on 03/26/21 a home staff member administered two doses of trazodone instead of one to C2. The staff member left a note in the Medication Administration Record (MAR) to "let the next person (either supervisor or nurse) know." The staff member realized the error when she/he went to initial off what was administered. The staff member did not report the error to the home manager or nurse. A review of the physician's order for 03/01/21 to 03/31/21 was trazodone tab, 50 mg., take 0.5 (25 mg) by mouth once daily at bedtime. The dosage given by the staff member was double the amount.	9 189		

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9 189	Continued From page 8 On the following day, 03/27/21 at 03:45 PM, the Home Manager (HM)2 found the staff member's note regarding the medication error. HM2 reported the error to the nurse. Interview was done with the Nurse Manager (NM) on 01/19/22 at 02:26 PM in the facility's conference room. NM recalled the incident and reported the staff member was written up and retrained following the incident.	9 189		
9 279	11-99-29(a)(10) RESIDENT'S RIGHTS Written policies regarding the rights and responsibilities of residents during their stay in the facility shall be established and shall be made available to the resident, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. The facility's policies and procedures shall provide that each individual admitted to the facility shall: Be treated with consideration, respect and full recognition of their dignity and individuality, including privacy in treatment and in care. This Statute is not met as evidenced by: Based on observations and interview with staff members, the facility failed to promote the dignity for 1 of 2 clients in the sample. Client (C)2 has a condom catheter (external catheter which collects urine as it drains out of the bladder through a tube and into a collection bag). C2 was taken for a physician's appointment in the community and his collection bag was not covered.	9 279		

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9 279	Continued From page 9 Findings include: Observed C2 arrive at the day program on 01/18/22 at 11:35 AM. The Assistant Center Manager (ACM) commented C2 was returning from a physician's appointment. At 11:37 AM observed C2's collection bag was hanging at the back of the wheelchair and not covered. The collection bag contained urine. At 12:15 PM interviewed Day Program Staff (DPS)1 in the classroom. DPS1 reported C2 has a cover for the collection bag, however, had diarrhea yesterday which spilled onto the catheter bag cover, soiling it. At 12:20 PM, the ACM checked C2's backpack for a cover. She confirmed there was no cover in the backpack and stated usually C2's catheter bag is covered. C2 spent the rest of the day at the program with his catheter bag uncovered. The Home Manager (HM) was interviewed on 01/18/22 at 04:02 PM in the clients' home. Inquired whether C2 has a covering for his catheter bag. HM confirmed C2 has a covering. HM reported that he was not aware the catheter bag cover was soiled and did not wash it yesterday. HM reported C2 has only one catheter bag cover which the nurse provided. On 01/19/22 at 08:30 AM observed C2 in the classroom with a black cover for the catheter bag. Interviewed the Nurse Manager (NM) on 01/19/22 at 02:26 PM in the conference room. The NM confirmed C2 has one catheter bag cover.	9 279		