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	125058	A. BUILDING ______ B. WING ______	R 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	**1180 WAIANUENUE AVENUE HILO, HI 96720**

(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 On 12/21/22 an onsite revisit was conducted by the Office of Health Care Assurance for the recertification survey completed on 10/14/22 in which harm was identified at 483.25(b)(1), Pressure Ulcers and 483.25(k), Pain Management. The facility was found to be in compliance with the deficiencies cited during the recertification survey. The facility was found not to be in compliance with regulatory requirements at 42 CFR 483, Subpart B. The survey team entered the facility on 12/19/22 and was notified of a COVID-19 outbreak. The facility census was 60. The facility reported five positive residents and two positive employees. On 12/20/22, the facility notified the survey team of additional two positive employees. Deficient practice was identified at §483.80, Infection Control and §483.45(h) Storage of Drugs and Bilogicals.	{F 000}		
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	F 761		1/14/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/06/2023

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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F 761	Continued From page 1 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: Based on observation and interview, the facility failed to ensure all medications used in the facility were stored in accordance with professional standards. Proper storage practices of all medications and biologicals are necessary to ensure their integrity, safety, and efficacy. Findings include: On 12/20/22 at 07:45 AM, observed eight (8) boxes of Influenza Vaccines, each containing ten (10) single-dose pre-filled syringes for a total of eighty (80) doses, on one of the refrigerator (fridge) shelves in the Adult Day Health (ADH) Room. On the same shelf in the fridge was a brown paper bag with half of a moldy egg salad sandwich in a plastic container with a date label that read "10.17," and a large plastic bag with approximately twenty (20) laboratory (lab) specimen bags, each bag containing a specimen swab sealed in a labeled specimen tube and a lab slip. At 08:12 AM, observed Certified Nurse Aide (CNA)1 enter the ADH Room and collect some lab specimen bags from the "Quiet Room [a small	F 761	F761: Label/Store Drugs and Biologicals SS: D CORRECTIVE ACTION: Removed medication from ADH (Adult Day Health) refrigerator on 12/20/22. IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected by this deficiency. All refrigerators in the nursing units were inspected for improper storage of medications on 12/20/22. MEASURE ANDE SYSTEMATIC CHANGES TO PREVENT RECURRENCE: All licensed nursing staff will be educated on proper medication storage by 01/14/23.	

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F 761	Continued From page 2 room within the larger ADH Room]." Prior to CNA1's exit from the ADH Room, asked her if she needed to collect the lab specimens in the ADH Room fridge as well. CNA1 checked the ADH Room fridge and confirmed that there were COVID-19 test samples from staff in there that she would have missed because they should have been placed in "the other [Quiet Room] fridge only." Observed CNA1 look in the brown paper bag containing the moldy sandwich and put it back in the fridge before leaving with all the lab specimen bags from both fridges. At 08:48 AM, an interview was done with the Director of Nursing (DON) and the Infection Preventionist (IP) in the second-floor hallway outside of the IP's office. The DON confirmed that lab specimens should be kept only in the Quiet Room fridge, and never placed into the same fridge as any food items or medications. The DON stated that no one should be using the ADH Room fridge at all currently since the ADH Program was still closed. The DON assured the State Agency (SA) that the fridge would be cleaned and the medications [vaccines] removed for proper storage.	F 761	ADH (Adult Day Health) refrigerator has been added to Housekeeping daily rounding. MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS: The Housekeeping daily rounding forms will be audited for 90 days or until 100% compliance is met in order to monitor for the effectiveness of these changes and to ensure correction is achieved and sustained. The results of these audits will be reviewed in QAPI.	
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	F 880		1/14/23

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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 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

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F 880	Continued From page 4 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. §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, and record review, in response to a COVID-19 outbreak identified on 12/15/22, 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 standard and transmission-based precautions to control and prevent the spread of COVID-19. In addition, the facility failed to ensure staff conducting point-of-care (POC) COVID-19 self-testing conducted the testing per CDC and manufacturer guidelines and failed to ensure staff handling the collected specimens followed standard precautions. This deficient practice has the potential to contribute to the transmission and spread of COVID-19 in the facility, compromising resident, staff, and visitor safety. Findings include:	F 880	F880 INFECTION PREVENTION & CONTROL SS: F CORRECTIVE ACTION: COVID specimens removed and delivered to lab on 12/20/22. Staff educated on and implemented COVID UNIT PPE on 12/20/22. Staff member re-educated on proper protocol for COVID specimen collecton on 12/20/22. CNA #1 educated on protocol for handling lab specimens and Hand Hygiene on 12/20/22. Dedicated receptacles for used PPE was provided for each COVID isolation room in	

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1) Cross-reference to F761 Medication Storage and Labeling. The facility failed to ensure the proper storage of collected COVID-19 test samples as evidenced by collected samples observed held in the same refrigerator as food and Influenza Vaccines.

2) On 12/19/22 at 01:42 PM, an interview was done with the Infection Preventionist (IP) in the Adult Day Health (ADH) Room. The IP confirmed that the facility had an outbreak of COVID-19, identified on 12/15/22, and initially included two (2) residents (R). Mass testing was conducted on 12/15/22 and 12/16/22 in response, with three (3) additional residents and two (2) staff identified positive for COVID-19. All five (5) residents were moved to the Red Zone on 12/15/22. Mass testing was being continued twice a week (on Mondays and Thursdays) until the facility had reached fourteen (14) days with no new cases.

The IP reported that the Red Zone was staffed with one dedicated Certified Nurse Aide (CNA) who remained on the unit, one CNA who floated between the Red and Green Zones, and usually one licensed Nurse who was responsible for the entire first floor (including residents on other isolation types), working back and forth between Red and Green Zones their whole shift.

The IP described the facility's current Red Zone protocol as one respirator and face shield, changed out between the Red and Green Zones, with the face shields cleaned at the end of shift, and the respirators worn for five donnings and doffings. In addition, staff were to don gloves and a gown upon entering, with the gown to be doffed upon exit of the Red Zone (in the anteroom). The

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the Red Zone on 12/20/22.

Dirty PPE removed from clean PPE area on 12/20/22.

Housekeeping staff assignment adjustment on 12/20/22.

CNA #3 educated on Infection Control, PPE use, and Hand Hygiene on 12/21/22.

LVN #1 education on PPE use for Transmission Based Precautions on 12/20/22.

Cart for Room 234 was inspected and PPE that was not clearly marked were discarded on 12/20/22.

Receptacles were restocked with new PPE including different sized N95s for staff use on 12/20/22.

IDENTIFYING OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED AND WHAT CORRECTIVE ACTION WILL BE TAKEN:

All residents have the potential to be affected by this deficiency.

All refrigerators in the nursing units inspected for improper storage of COVID specimens.

Audit completed to identify all residents in the facility on Transmission Based Precautions to ensure proper use of PPE,

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face shields and respirators were also doffed upon exit of the Red Zone and were to be kept in labeled paper bags in plastic personal protective equipment (PPE) carts in the anteroom. Upon questioning by the State Agency (SA), the IP confirmed that the gowns were not changed between Red Zone residents "because they all have COVID." The IP was asked to provide the Centers for Disease Control and Prevention (CDC) guidance or recommendations the facility was following.

On 12/20/22 at 07:40 AM, observed a staff member sitting at table in the ADH Room with a laboratory (lab) specimen bag and lab collection swab on the table in front of her. The staff member was not wearing gloves as she placed the specimen container containing the collection swab into the bag and carried it into the Quiet Room (a room within the larger ADH Room), placing it in the refrigerator (fridge), nor did she wipe the table [test area] down prior to exiting the ADH Room.

At 08:12 AM, observed Certified Nurse Aide (CNA)1 enter the ADH Room and collect some lab specimen bags from the Quiet Room. Prior to CNA1's exit from the ADH Room, asked her if she needed to collect the lab specimens in the ADH Room fridge as well. CNA1 checked the ADH Room fridge and confirmed that there were additional COVID-19 test samples from staff in there that she would have missed because they should have been placed in "the other [Quiet Room] fridge only." While inspecting some of the collected specimens, CNA1 was observed taking individual specimen bags out of the larger bag and placing them on a counter in the ADH Room. CNA1 did not clean the counter prior to exiting

F 880

used PPE receptacles provided, and clean PPE supplies stocked.

An audit of all PPE carts completed to ensure that any PPE that was not clearly marked were discarded.

MEASURE AND SYSTEMATIC CHANGES TO PREVENT RECURRENCE

All staff to be educated on COVID-19 specimen storage, lab specimen handling, collection, and hand hygiene completed by 01/14/23.

All staff to be educated on PPE Use for Transmission Based Precautions; including proper storage completed by 01/14/23.

All staff to be educated on How to Set Up a Room for Transmission Based Precautions completed by 01/14/23.

All staff to be educated on Hand Hygiene completed by 01/14/23.

Housekeeping staff were educated on COVID unit assignments in the Red Zone completed on 12/28/22.

A new Infection Control Rounding tool was developed which includes monitoring of proper use of PPE, COVID specimen collection and handling observations, inspection of Transmission Based Precaution rooms for proper set up of

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the room. In addition, CNA1 was not wearing gloves as she handled the collected specimens, nor was she observed performing hand hygiene at any point while handling the specimens, or while entering and exiting the room(s).

At 08:48 AM, an interview was done with the Director of Nursing (DON) and the IP in the second-floor hallway outside of the IP's office. The DON confirmed that lab specimens should be kept only in the Quiet Room fridge, and never placed into the same fridge as any food items or medications. When asked about continued transmission of COVID-19, the IP confirmed that two additional staff members had been identified from the testing conducted the day before.

In response to the SA inquiry regarding using the same gown between Red Zone residents, the IP confirmed that the facility had incorrectly been following old guidance, and that staff should be changing gowns between residents.

When asked about self-collection of lab specimens for staff and the handling of collected specimens, the DON confirmed that staff should be wiping down their testing area before and after self-swabbing and agreed that staff handling collected specimens should be wearing gloves.

On 12/20/22 at 04:00 PM, observations were done in the Red Zone. All resident room doors were open, and at one point R8 was observed reversing his motorized wheelchair into the hallway, turning it slightly, then advancing it back into his room. CNA2 was observed exiting room 149 wearing a disposable gown that she doffed in the hallway and disposed of in one of two gown receptacles placed in the hallway. Confirmed

F 880

PPE carts, Sufficient PPE supplies, Labeling of used PPE and Hand Hygiene.

MONITORING CORRECTIVE ACTION FOR SUSTAINED CORRECTIONS:

Housekeeping Daily Rounding Forms will be audited for 90 days or until 100% compliance is met in order to monitor for the effectiveness of these changes and to ensure correction is achieved and sustained. The results of these audits will be reviewed in QAPI.

Infection Control Rounding tool will be completed weekly for 12 weeks or until 100% compliance is met in order to monitor the effectiveness of these changed and to ensure correction is achieved and sustained. The results of these roundings will be reviewed in QAPI.

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with the Charge Nurse (CN)2 that despite being instructed to change gowns between residents, the Red Zone had only two used gown receptacles, located in the Red Zone hallway, and one used gown receptacle located in the Red Zone anteroom. CN2 questioned the facility's current use of the anteroom as a room to doff used gowns and store used face shields and respirators, when 'clean' PPE was also donned in the same area. The SA confirmed that the waste receptacles in the hallway and anteroom created a 'dirty' environment (area of increased potential transmission) and that standard precautions would dictate waste receptacles and the doffing of used PPE at the exit of each Red Zone room, thereby keeping the hallway and anteroom as 'clean' environments. Concurrently, two housekeepers were observed cleaning the Red Zone rooms and collecting trash. One housekeeper changed her gown between rooms while the second housekeeper did not.

On 12/21/22 at 08:30 AM, the following was noted in the facility's COVID 19 Playbook, last revised 09/26/2022:

"HCP [health care personnel] assigned to care for COVID isolation patients should not care for other patients who are either immunosuppressed or in other isolation types (for example, airborne ... or contact ...)."

"Minimize movement in and out of the red zone."

During concurrent review of the facility's LTC [Long-Term Care]: Infection Prevention and Control Program, last reviewed and "Effective 07/2022", the following was noted under the Procedure section for Standard Precautions:

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"Remove and discard PPE before leaving the resident's room or cubicle using proper technique to avoid contamination."

Under the section for Droplet Plus precautions, the following was noted:

"Designate staff to care for ill residents and minimize staff movement between areas in the facility with illness and areas not affected by outbreak."

On 12/21/22 at 10:32 AM, additional observations were done in the Red Zone. CNA3 was observed in the hallway with a bag of trash wearing a disposable gown, a face shield, a respirator, and no gloves. Observed CNA3 carry the trash into Room 155 where she discarded it. Watched CNA3 adjust R2's bedding and pillows before exiting the room and performing hand hygiene. Still wearing the same gown, observed CNA3 enter Room 148 and assist R21.

At 10:38 AM, an interview was done with CNA3 in the Red Zone hallway. CNA3 apologized and acknowledged that she forgot to put on gloves and change her gown between residents. CNA3 stated that currently there is a clean PPE cart outside of Rooms 148 and 154 only, and she would like to see one outside of every room because that would help remind her to change her gown before entering a new room.

3) On 12/20/22 at 09:40 AM observed a Licensed Vocational Nurse (LVN)1 in Room 234. The LVN was wearing personal protective equipment (gloves, gown, face shield, and an

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N95 face mask). There were two plastic bins to the left of the door. There was a laminated sign posted next to the door. The sign was titled "Contact/Droplet Precaution" with step-by-step instructions for donning (putting on) personal protective equipment (PPE) and doffing (removing) PPE.

LVN1 stood in the doorway and stated she was waiting for assistance. LVN1 was asked why R31 is on contact/droplet precautions. LVN replied R31's roommate, R33 was positive for COVID-19 and has been moved to another unit. LVN clarified due to COVID-19 exposure; the facility is taking precautions with R31.

The Contact/Droplet Precaution sign listed the following steps for doffing PPE with an N95:

1) Remove Gloves.
2) Remove Gown.
3) Exit room.
4) Hand Hygiene.
5) Remove Face Shield, place in plastic bag and store in drawer.
6) Remove N95 mask, place in brown bag and store in drawer.
7) Hand Hygiene.
8) Don surgical mask.
9) Don Face shield.
10) Hand Hygiene.

At 09:45 AM observed LVN1 exiting R31's room. LVN removed gloves and gown and discarded items in a bin placed inside the resident's room. LVN was walking down the hall toward the nursing station (off the unit). LVN was stopped to inquire whether steps 5 and 6 were completed. Provided clarification to LVN1 regarding the sign and asked if she placed her face shield in a

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F 880	Continued From page 11 plastic bag and stored it in the bin and placed her face mask in a paper bag and stored in the drawer. Requested LVN show where she stored her face shield and face mask, was it labeled with her name? LVN stated that she forgot to change shield and mask. LVN opened the drawers of the narrow black bin and there were paper bags in it with masks, did not see prominent label of staff members' names on the bag. LVN opened all the drawers of the narrow bin and there was no observation of face shields in plastic bags stored in the drawers. LVN opened the drawers of the white wider bin, there was a roll of plastic bags. Did not observe clean face shields or N95 stored in the drawers for staff to change into (Steps 8 and 9). There were no sanitizing wipes or gloves provided on the cart for staff members use. LVN stated that she can get clean face shields and N95 face masks to put in the white cart. Followed LVN1 to the lobby of the facility where she took some face shields out of the bin marked clean face shields. Commented to the LVN it is difficult to know which N95 face masks to keep in stock as staff members may have been fitted for various masks. At 09:55 AM concurrent observation was made with the IP. Upon arrival to the resident's room, LVN1 was observed stocking N95 face masks in the white drawers. IP confirmed the step-by-step instructions should be followed by staff members. Informed IP the drawers were not supplied with clean face shields and N95 face masks for staff use. Further queried when does staff throw away their used face shields and masks. IP stated it should be done at the end of every shift.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING ______ B. WING ______	R 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE HILO, HI 96720

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