Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125007	A. BUILDING: _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MAKUA - KAHULUI	472 KAULANA STREET KAHULUI, HI 96732

(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	11-94.2-0 Initial Comments The Department of Health, Office of Health Care Assurance has accepted the federal Medicare recertification of this facility for state relicensing purposes. Refer to the federal Medicare recertification survey report. The facility was also not compliant with Chapter 11-94.2-6(e) Hawaii Administrative Rules (HAR). Survey Census: 200 Sample Size: 63	4 000		
41095	11-94.2-53 (b) Infection control (b) The facility shall have provisions for isolating residents with infectious diseases until appropriate transfers can be made. (1) The facility shall have a written policy that outlines proper isolation and infection control techniques and practices; (2) At least one single bedroom shall be designated as an isolation room as needed and shall have: (A) An adjoining toilet room with nurses' call system, a lavatory, and a toilet; (B) Appropriate hand-washing facilities available to all staff; and (C) Appropriate methods for cleaning and disposing of contaminated materials and equipment; (3) The facility shall ensure that visual observations of the resident can be made in each isolation room:	41095		

Office of Health Care Assurance

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

Electronically Signed

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41095	Continued From page 1 (A) By means of the view window in each isolation room; or (B) By an approved mechanical system e.g., closed circuit television monitoring; (4) The facility shall have documented evidence that every employee has both an initial employment evaluation and an annual health evaluation. These evaluations shall be specifically oriented to determine the presence of any infectious disease liable to harm a resident; (5) Skin lesions, respiratory tract symptoms, and diarrhea shall be considered presumptive evidence of infectious disease. Any employee who develops evidence of an infection must be immediately excluded from any duties relating to food handling or direct resident contact until such time as a physician certifies it is safe for the employee to resume such duties; (6) There shall be a documented record that every employee and resident have an initial and an annual tuberculosis (TB) clearance. Facilities shall comply with the most current and updated guidelines as set forth in chapter 11-164, Exhibit A; and (7) When a known negative tuberculin skin test on an employee or resident converts to a positive test, it shall be considered a new case of tuberculosis infection and shall be reported to the department. [Eff] (Auth: HRS §§321-9, 321-11) (Imp: HRS §§321-9, 321-11) This Statute is not met as evidenced by: Based on record review and interview, the facility failed to ensure every employee has an annual	41095		

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41095	Continued From page 2 health evaluation and annual tuberculosis (TB) clearance for one of eight (Staff (S)8) sampled. As a result of this deficient practice, residents are at potential risk of more than minimal harm due to the potential presence of any infectious disease, liable to harm a resident. Findings include: The Office of Health Care Assurance (OHCA)-16 form (audits a random selection of new/annual employees for the date of a health evaluation and TB test) was given to the Director of Nursing (DON) for completion. Upon receiving the facility completed form, identified S8's annual health evaluation and TB test was completed on 09/15/23, which is past due annual due date (09/15/24). On 10/17/24 at 09:43 AM, conducted a concurrent record review and interview with Scheduler (SCH)1. SCH1 confirmed S8 has been providing direct care to residents after his/her annual health and TB test date expired (09/15/24) and is currently on the schedule. On 10/17/24 at 09:55 AM, reviewed the OHCA-16 form with the Administrator and informed her that S8's annual health evaluation and TB test was beyond the annual date. No additional document(s) were provided by the facility regarding S8's annual health evaluation and TB test.	41095		