STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125056	A. BUILDING _____ B. WING _____	**06/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALE MAKUA HEALTH SERVICES	**1540 LOWER MAIN STREET WAILUKU, HI 96793**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and review of policies and procedures, the facility failed to ensure infection control and prevention practices were maintained and implemented to prevent the transmission of communicable diseases and infections as evidenced by Nursing Staff (NS)1 not cleaning/disinfecting a shared resident-care equipment (blood pressure cuff) prior to or after use, Nursing Supervisor (S)5 placing a gait belt (unknown if the gait belt was clean or previously used) in the clean linen bin, and incomplete screening of signs and symptoms of COVID-19 for staff identified as working in another healthcare setting. As a result of these deficiencies, residents are at an increased risk of potential exposure to infection. Findings include: 1. On 06/18/20 at 09:21 AM, observed NS1 enter room [ROOM NUMBER] with a blood pressure cuff (BPC) and take Resident (R)7's blood pressure. The BPC was not disinfected prior to NS1 entering room [ROOM NUMBER]. After exiting room [ROOM NUMBER], NS1 went into room [ROOM NUMBER] and assisted a resident. After exiting room [ROOM NUMBER], NS1 proceeded to prepare medication and provide care for other residents. Although disinfecting wipes were available, NS1 was not observed to disinfect/sanitize the BPC. At 09:40 AM, inquired with NS1 regarding expectation and practice for disinfecting BPC (shared resident-care equipment) between residents. NS1 stated the BPC should be cleaned after it is used on a resident. NS1 confirmed the BPC was not cleaned/disinfected prior to or after use on R7. Review of the facility's policy and procedure titled Cleaning, Disinfecting and Sterilization documents supplies, and equipment will be cleaned immediately after use. The policy and procedure for Standard Precautions documents resident care equipment should be adequately cleaned and/or disinfected before use for another resident. 2. On 06/18/20 at 09:15 AM, observed a white fabric gait belt, with brown spots, hanging on the side of a metal bin with closed drawers. The brown spots had an irregular pattern and was not consistent with the pattern of the gait belt's metal fastener. At 09:50 AM, observed Nursing Supervisor (S)5 walk up to the metal bin and place the fabric gait belt, that was hanging on the side of the metal bin, immediately into the metal bin. Inquired with S5 regarding the content within the metal bin. S5 stated the metal bin contained clean linen. Then inquired if the gait belt was clean and pointed out the brown spots on the gait belt. S5 stated he/she did not know if the gait belt had been previously used and did not initially see the brown spots on the gait belt. After seeing the brown spot, S5 confirmed it looked dirty and should have been placed in the laundry bin and sent to laundry for cleaning after it was used. On 06/18/20 at 10:00 AM, inquired with Therapy Staff (TS)2 regarding cleaning/disinfecting gait belts. TS2 stated gait belts were cleaned by wiping the belt down with a wipe located in the therapy room. TS2 could not provide the name of the wipes he/she used to clean/disinfect the gait belts. On 06/18/20 at 10:10 AM, entered the Multipurpose Room, used as a designated occupational and physical therapy room. Observed seven gait belts and various resistance bands hanging on the physical therapy parallel bars which is used to assist residents for gait training and walking assistance. Inquired with TS4 how used gait belts are disinfected/laundered. TS4 stated gait belts hanging on the parallel bars were previously used on residents during therapy sessions and should have been placed in the dirty linen bin (located in the restroom) to be laundered. Requested a policy and procedure from the Director of Nursing (DON) for properly cleaning/laundering of gait belts on 06/18/20 at 10:38 AM. The DON could not provide a policy and procedure. 3. On 06/18/20 at 11:40 AM, conducted a review of the facility's employee COVID-19 screening log. Randomly selected to review documents for certified nurse aide (CNA)4. The facility identified CNA4 as an employee who works in another healthcare setting which requires CNA4's temperature to be screened twice (before and after) a shift as indicated in the facility's mitigation plan. Review of the May 2020 employee logs which requires staff members to answer screening questions daily and separate log which documents two temperatures (before/after shift) temperatures for staff the facilities identified as working in other facilities, noted no documentation of a second temperature for CNA4 on seven different eight-hour shifts (5/1; 5/8; 5/9; 5/12; 5/16; 5/27; and 5/30). At 12:15 PM, conducted an interview with the Administrator and the DON regarding the facility's screening process. The DON confirmed there was no documentation of CNA4's temperature post shift those seven, eight-hour shifts. Inquired if a designee or DON was monitoring the completion of the screening log daily as outlined in the facility's mitigation plan. Review of another document, Managing our risks amidst the COVID-19 pandemic 3/27/20, confirms the DON (or designee when not in building) will monitor completion of log each day to ensure the staff are compliant with the twice daily screening. DON and Administrator confirmed screening logs were not monitored daily for completion by designee staff or DON and were not aware screening logs were incomplete. Inquired with the DON regarding how the facility conveys COVID-19 updates to all staff. DON stated staff are updated through huddles conducted on the units prior to the start of shift and staff are required to review informational binders located at the nursing station. DON provided a copy of In-Service Sign-In Sheets and explained staff's signature indicates an agreement to read the binder at the beginning of his/her shift for COVID-19 updates. Staff are responsible to review the binder each day a staff works. Initially, the In-Service Sign-In Sheet contained a signature in CNA4's designated signature box dated 04/01/20. However, when copies were provided, the DON stated he/she had used white-out to cover the original signature because another staff had erroneously signed the wrong box. The DON could not provide documentation ensuring CNA4 received vital updates related to COVID-19.

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