STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALOLO CHINESE HOME	**2459 10TH AVENUE HONOLULU, HI 96816**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a comprehensive care plan for COVID-19 illness was developed for one of three residents (Resident (R) 1) in the case sample. This deficient practice has the potential to affect any resident who may become ill with COVID-19 in the facility. Finding Includes: Observation and interview with Resident (R)1 was done on 09/23/2020 at approximately 09:50 AM. R1 was alert, oriented and able to discuss her care after being confirmed COVID-19 positive on 09/03/20. R1 expressed she, did not like the isolation--it was hard. R1 said her two granddaughters drove from the west side of Oahu to bring food to her daily and that this provided the comfort she needed during her illness. R1 said at present, with her recent recovery from COVID-19, she has begun receiving short term rehabilitation (rehab) services. R1 however, was uncertain when she was going to return home, but thought it would be soon. R1 said she would then continue with home health therapy. Record review found R1 was admitted from an acute hospital on [DATE]. Although testing negative prior to her admission to the facility for short term rehab, she became symptomatic with a fever on 09/01/20. R1 was tested for the coronavirus on 09/01/20, and her results returned positive for COVID-19 on 09/03/20. R1 affirmed during her interview that she was then transferred to the facility's dedicated COVID-19 unit, and received continued care from designated nursing staff. However, R1's clinical record did not have a comprehensive plan of care for a resident with a COVID-19 illness. R1 should have had an admission assessment by day 14 including the development of a comprehensive care plan by day 21, which would have been on or around 09/18/20. Examples of nursing care interventions for COVID-19 could have included education on preventing the spread of COVID-19, education for resident/family members about the disease process, providing psychosocial support (with R1's expression of feeling isolated), methods to ease anxiety, teach breathing exercises, and include a progression in activities with recovery. During the afternoon exit conference with the NHA, DON and CEO on 09/24/20, the DON acknowledged there was no comprehensive care plan developed for R1 in this regard, and it was something they would start working on.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and a review of the facility's policy and procedures, the facility failed to implement proper infection prevention and control practices (IPCP) to prevent the potential development and transmission of COVID-19 and/or other communicable diseases/infection, which could be spread to the residents. This COVID-19 focused infection control survey found the facility's deficient practices as follows: 1) The facility failed to ensure COVID-19 screening for their employees, visitors, and vendors occurred at the sole designated point of screening/entry. This failure created a systemic issue with the potential to allow the entrance and/or transmission of the coronavirus which could affect all residents residing in their facility. 2) The facility failed to ensure the appropriate use of personal protective equipment, specifically the use of N95 respirators and no program to monitor it. 3) The facility failed to ensure direct accessibility to alcohol based hand rubs (ABHRs) in two resident halls. 4) The facility failed to ensure physician orders [REDACTED]. These deficient IPCP practices had the potential to place all residents, staff and visitors at risk for the development and transmission of communicable/contagious diseases, such as COVID-19. Findings Include: 1) On 09/23/20 at 10:20 AM, observation of the kitchen area was done. Across the kitchen door in the hallway, there was a table with a black binder containing information of people who were screened there. The table also had a non-contact thermometer, a liquid hand sanitizer bottle, a clipboard with preprinted Screened tags, and other items. This second screening site was confirmed by the Environmental Services Manager (EVS-M) at 10:29 AM. The EVS-M said the kitchen staff who arrived at 05:00 AM were screened at this location by either him or another staff. The EVS-M said, We don't want them to come through Farm Hall, the kitchen staff, and said their vendors, come here too, and the delivery people too. We screen them and they just come up to the table where they're screened, like (food company) on Thursdays with big pallets and drop off the load. Although he said these vendors were screened at this site, he also said some were screened on top, which was the Farm Hall screening site. (On entrance, the SA was told Farm Hall was the sole screening site for anyone to be cleared in order to enter the facility). The EVS-M further said the kitchen site was mainly limited to kitchen staff and for vendors who delivered medical supplies. For the medical supply vendors, he said they would drop the supplies off, and either he or another staff would go out to get it, and sometimes they did not screen (i.e., take the temperatures) of these vendors. For the cleaning of the non-contact thermometer and other equipment used to conduct the screenings at the kitchen site, the EVS-M and the DON acknowledged they had no EPA registered disinfectant wipes to clean these items they used to screen people with. In addition, a review of the kitchen screening log found several missing temperatures and screening dates, and noted that some of the recorded temperatures would be considered a medical emergency (hypothermia). Missing recorded temperatures of screened individuals were found on 08/20/20, 08/24/20, 09/03/20, and 09/14/20. In addition, there were three temperatures taken of individuals that were recorded at 94.2, 94.1 and 94.2 degrees Fahrenheit (F), which represents dangerously low body temperatures and considered a medical emergency. The Director of Nursing (DON) nodded and affirmed this. The EVS-M also acknowledged it and said he was not aware temperatures were not being recorded, or recorded as hypothermic readings and/or missing dates. A sample review of the log from 08/20 through 09/23/20 also found two screening entries without a date, and one with a date of 2/22/20, which the DON said was before the pandemic. A review of the screening log kept at the Farm Hall screening site for Nutrition and Dietary services was done. It was found there were similar low body temperature readings of 94.7, 94.2, 94.5, 94.8 and 93.9 degrees F. In addition, on 09/24/20, the SA observed the screening station in Farm Hall was unmanned. The SA saw two staff checking themselves in and putting their screened stickers on themselves. During the afternoon exit conference, the CEO asked the DON to call office staff to assist with it as the screening table was left unmanned at that time. A review of the facility's policy, Screening Protocol during COVID-19, revised 08/03/20, stated, This policy addresses the facility's screening process for all individuals who arrive to the facility, including, employees, visitors, volunteers, vendors, etc. 1. All screening is conducted in Farm Hall - screening table with supplies are stocked. 3. Screening process includes, taking temperature, asking for COVID-10 symptoms, . Any individuals with temperatures >100 F will be re-temped using an alternative method. Thus, the facility's screening process was not followed as evidenced by the survey observations, record review and interviews. 2) During a tour of the central supply room and interview with the EVS-M on 09/23/20 at 10:45 AM, the EVS-M stated their N95 respirators were the 3M 8210 model. He stated these were, the universal size and used by the nursing staff who cared for R1. On 09/24/20 a re-interview of the EVS-M was done at 8:35 AM. He stated that a N95 universal fit test kit was kept in the Weinberg Hall medication room. He stated this was not the KN95, but the official N95 respirator, catalog number 8210. At 08:50 AM, the SA saw the N95 fit test kit and the Assistant Director of Nursing (ADON) was interviewed. The ADON stated they had no dedicated respiratory administrator,

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) but explained the procedure for an N95 fit test. She affirmed there was only one size, which was the N95 respirator given by the EVS-M. It was further revealed they used the seal check method to achieve a tight fit to wear this universal N95. When the ADON was further queried how the testing occurred, she said, Whoever is testing them would be the one to spray it about 15 times, to see if they could smell or taste anything. However, when asked where their fit test logs were kept, the ADON stated they did not keep an actual log and they did not think about that. For the staff who cared for R1, the ADON said she was not involved in that, but I know they did the seal check. Review of the Type N95 NIOSH Approved Respirator stated at the Warnings and Limitations page: 1. Respirators must be selected, fitted and maintained in accordance with applicable Health & Safety Standards . requires every user to be fit tested annually and the employer to have a written respiratory program. Another brochure, the frequently asked questions (FAQs) provided to the SA by the ADON at 09:04 AM, stated the User Seal Check (a method to ensure the wearer of the respirator is properly worn), stated this check was not a substitute for a fit test. It also said, A user should only wear respiratory models with which they have achieved a successful fit test within the last year. Interviews done on 09/24/20 with a registered nurse (RN)2 at 10:23 AM and a certified nurse aide (CNA)1 at 11:04 AM, both who cared for R1, verified they were fit tested by the previous DON with a different N95 model. CNA1 affirmed it was this year, stating, Yeah, we had COVID already, (meaning the pandemic occurred), but was not given any documentation of his fit test then. At 09:13 AM, the DON joined the ADON, EVS-M and RN1 at the nurse's station. After the interview with the ADON was done, the DON stated, We have to build a program, and acknowledged he had not been aware they did not have one anymore. 3) On 09/23/20 at approximately 10:07 AM in the Weinberg Hall, the SA came out of R1's room to sanitize their hands. However, it was found the alcohol based hand rub (ABHR) on the wall between rooms 119-121 was not accessible because a linen cart with a blue covering was positioned beneath it and blocked access to it. The surveyor tried to reach over the cart, but could not. Then, it was found the ABHR between rooms 122-120 was also blocked with another linen cart. The DON observed this with the SA. In addition, even if a taller individual could reach over the carts to dispense the alcohol rub from the ABHR, there was a potential the alcohol rub could drip onto the linen cart and require additional clean-up. During the tour of the Harry(NAME)Hall on 09/23/20 at 12:50 PM, observation found another ABHR being blocked by a medication cart. The cart had been pushed against the wall with a clear water pitcher pushing against the ABHR causing it to tilt to the right. Due to the off base position of the ABHR, the SA was hesitant to use it as it could potentially fall off its hinge. Also, there was the same potential the alcohol rub could drip onto the medication cart. The DON nodded when this was discussed and shown to him. 4) Observation and tour on the Pikake unit revealed that R2 was recently admitted from an acute hospital on [DATE]. During the tour on 09/23/20 at 12:44 PM, there was signage placed at the entrance to her room for both Droplet and Contact Precautions. R2 was considered a new admission which automatically placed her on a Persons Under Investigation (PUI) status. However, her clinical record did not contain a physician order [REDACTED]. An interview with the DON was done on 09/24/20, about their policy, Facility COVID-19 Test Protocol, dated 09/01/20. This policy stated, . The testing of staff and residents, as indicated by admissions of new residents as PUI, or residents / staff with confirmed CoV2 infection will be completed as a standing order under the direction of the facility Medical Director. After a review of this policy with the DON, he affirmed there was no written standing order in any residents' clinical charts at this time. 6) On 09/23/20 at 08:26 AM, during an interview with the DON, he stated all new admissions are considered Persons Under Investigation (PUI) and these residents were automatically placed on droplet precautions. On 09/23/20 at 12:44 PM during a tour of the Pikake floor, surveyor observed a droplet precaution sign in front of R3's door. R3 was admitted to the facility on [DATE] and was considered a new admission. However, on 09/23/20 at 2:55 PM, the record review (RR) of R3 for the physician's orders [REDACTED]. On 09/23/20 during an interview with the DON, he affirmed this by stating, Will not see any physician order [REDACTED].