

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/02/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ARCADIA RETIREMENT RESIDENCE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1434 PUNAHOU STREET HONOLULU, HI 96822</b>		
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F 000	INITIAL COMMENTS  A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 01/27/21 to 02/02/21. The facility was not to be in substantial compliance with 42 CFR §483 subpart B. One facility reported incident (ACTS #8061) was investigated and not substantiated.	F 000			
F 550 SS=D	Survey Census: 71 Sample Size: 42 Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)  §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States.  §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.  §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview with residents, the facility did not ensure residents were treated with respect and dignity by speaking in a non-dominant language of the facility while providing care.  Findings include:  Resident Council Interview was done on 02/01/21 at 10:35 AM, two residents reported staff members speaking in the non-dominant language of the facility. One resident reported staff members speak in a non-dominant language while providing care. Another resident reported when staff members don't speak in English she is unable to understand what they are saying.	F 550			
F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi)  §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:	F 574			

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F 574	Continued From page 2 (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42	F 574			

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F 574	<p>Continued From page 3</p> <p>U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)</p> <p>(iii) Information regarding Medicare and Medicaid eligibility and coverage;</p> <p>(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;</p> <p>(v) Contact information for the Medicaid Fraud Control Unit; and</p> <p>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview with residents, the facility did not ensure postings which include names, addresses (mail and email) and telephone numbers of the State Long-term Care Ombudsman program and the State Agency to formally complain were provided to the residents. Although postings were found, the residents were not aware of where to find the information.</p> <p>Findings include:</p> <p>Resident Council interview was done on 02/01/21 at 10:35 AM. Inquired whether residents knew where the ombudsman's contact information is</p>	F 574			

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F 574	Continued From page 4 posted. The residents were not familiar with the Ombudsman. The residents were not familiar with the State Agency.  On 02/02/21 observed the facility had brochures regarding Ombudsman services on a rack outside of the third floor dining room, the second floor dining room on the Waikiki unit, and across the nurse's station on the second floor Ewa unit. Ombudsman brochures were available; however, placed too high on the rack to be accessible for residents seated in a wheelchair. The contact information for the Ombudsman was not posted.  The name and phone number for the State Agency and the name and phone number of the facility's Administrator was affixed to the bottom of the all the racks. However, the signage was blocked by the water cooler on the second floor, Waikiki unit.	F 574			
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)  §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.  §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys,	F 577			

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F 577	<p>Continued From page 5</p> <p>certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and</p> <p>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.</p> <p>(iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview with residents, the facility did not ensure residents are aware the results of the state inspection is available to read and readily accessible to residents, family members and legal representatives of residents. Although three of four units provided a copy, the residents were unaware of where to locate the folder containing the report.</p> <p>Findings include:</p> <p>Resident Council interview was done on 02/01/21 at 10:35 AM. Inquired whether residents know where the results of the most recent State survey is located. Residents were unaware of where to find the report to review.</p> <p>On 02/02/21 observed the results of the State Agency's last survey was in a rack located on the third floor outside of the Waikiki and Ewa units' dining rooms. The second floor Ewa unit observed a rack with the State Agency results outside of the dining room. The survey results were not located on the second floor Waikiki unit.</p> <p>Although the results were posted on three of the</p>	F 577			

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F 577	Continued From page 6 four units, the residents reported they are unaware of where to find the report.	F 577			
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4)  §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.  §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.  §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.  §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information	F 585			

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F 585	Continued From page 7 of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a	F 585			



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F 585	Continued From page 8 summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview with residents, the facility did not ensure residents are aware of how to file a grievance.  Findings include:  Resident Council Interview was done on 02/01/21 at 10:35 AM. Inquired whether residents know how to file a grievance. Residents stated that they are not aware of how to file a grievance.	F 585			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689			

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F 689	<p>Continued From page 9</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, and interviews with staff member, the facility failed to implement interventions, including adequate supervision consistent with the resident's needs, goals, and care plan to prevent an avoidable fall for 1 out of 4 residents (Resident (R) 17) that resulted in sustaining a fracture to right arm and significant weight loss.</p> <p>Findings Include:</p> <p>Review of R17's "Investigate Report Following Adverse Event" regarding an incident on 12/18/20, R17 had a witnessed fall and sustained fracture to right acute great tuberosity (prominent area of bone at the top of the humerus and is the attachment for the two large, powerful rotator cuff muscles, injured by landing directly onto the side of the shoulder or landing with arm outstretched) and humeral neck (bone in upper arm, located between the elbow and shoulder), causing right shoulder pain. The report further documented that on 12/18/20, R17 "saw a candy container shaped like Santa's "pants" and it was filled with candy canes. The resident stood up from her chair and walked to the nurse's station using her front wheeled walker. She grabbed a candy cane then turned around and took a few steps to give the candy to her husband without utilizing her front wheeled walker then walked back to the nurse's station. The resident remained standing in front of the nurse's station, but she was not holding on to her walker. The resident started to walk backwards, lost her balance, and fell down</p>	F 689			

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F 689	<p>Continued From page 10 on the carpeted floor."</p> <p>R17 is a 91-year-old with diagnoses of Alzheimer's Disease, muscle weakness (generalized), and unsteadiness on feet and with history of falls. Review of R17's Care Plan, documents a fall in her independent living apartment on 07/01/19, and subsequent falls at the facility on 02/05/20, 03/23/20, 04/12/20, 07/29/20, 11/19/20, and 12/18/20.</p> <p>Review of R17's quarterly Minimum Data Set (MDS) with an assessment reference date of 11/12/20, R17's Brief Interview Mental Status (BIMS) scored her at a 3 (severe cognitive impact). In Section G. Functional Status, under Transfers (how resident moves between surface including to and from bed, chair, wheelchair, standing position), R17 requires limited assistance with one-person physical assist. Walk in Room and Corridor, R17 requires limited assistance with one-person physical assist. Under Balance During Transitions and Walking, R17 scored a 2 (not steady, only able to stabilize with human assistance) for walking (with assistive device if used) and turning around and facing the opposite direction while walking.</p> <p>Review of R17's physician's encounter note dated on 11/23/20, R17 "...requires very close monitoring and prognosis remains guarded with high risk for adverse events due to advanced age and comorbidities- Due to Muscle weakness, unsteady gait needs close observation due to high risk for falls, traumatic injuries...Safety monitoring for falls prevention with consideration for poor memory and safety awareness"</p> <p>Review of "Fall Risk Assessment" dated on</p>	F 689			

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F 689	<p>Continued From page 11</p> <p>11/20/20 scored R17 at 11 and on 12/21/20 scored 12, according to the assessment this puts R17 at High Risk and requires appropriate fall interventions from Protocol II. However, from the 10 listed fall preventions in Protocol II only one was instituted, "1...Fall Prevention Protocol 1." The following were included in R17's "Fall Prevention Protocol 1:" Frequently reorient and repetitively reinforce use of call bell and ensure it is within reach, Reassess for a clutter-free, well-lit environment, Reinforce use of assistive devices, if used, Assess for safe footwear, Monitor use of eyeglasses and hearing aid if applicable, Consider Wellness Center for strengthening, if appropriate, and Evaluate the need for adjustment in resident's daily activity schedule.</p> <p>Interview with the Director of Nursing (DON) and Administrator on 02/02/21 at 10:17 AM noted that there were two Registered Nurses (RN), 14 and RN9, behind the Ewa Nurse's Station when the incident happened on 12/18/20. RN14 initially was right by R17 when she grabbed candy for her husband, but RN14 went behind the station before the incident took place. According to DON, R17 "is unpredictable sometimes" and does not use her walker all the time. She further stated that R17 needs general supervision when walking but not stand by assist, "many times when she does ambulate, we see her ambulating, so we can watch her." Concurrent review of the resident's care plan, effective from 11/18/20 to present, was done with the DON. Review of care plan under "Impaired Mobility/Falls" states that R17 "...has balance problems and required 1-man limited to extensive assistance with ambulation and transfers." Interventions for ambulation notes that R17 uses a front wheeled walker (FWW) "...with SBA [stand-by assistance] to contact guard</p>	F 689			

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F 689	<p>Continued From page 12</p> <p>assistance." According to DON stand-by assist means close by and contact guard assistance means "...you are pretty much next to her." Inquired whether the resident's fall could have been prevented if the two nurses had intervened, to ensure R17 safely returned to her chair next to her spouse. The DON did not respond. Further inquired whether the interdisciplinary team (IDT) met to discuss the fall, DON responded they met; however, there is no documentation. The DON reported the root cause was weakness, poor balance, and poor safety awareness. DON explained that if R17 ambulated without the walker staff is expected to redirect her to use her walker. DON confirmed that R17 has a FWW and is supposed to use but also has a purple cane that she will use.</p> <p>Observed R17 on 01/27/21 at 09:27 AM, 11:53 AM, 12:56 PM, and 01:41 PM, R17 sitting in the hallway in front of Ewa Nurse's station on a chair without FFW. On 01/28/21 at 07:52 AM, sleeping in her room with no FFW in sight and at 11:42 AM in the hallway in front of the Ewa Nurse's station eating lunch seated on a chair with a purple cane on her left side. On 02/01/21 at 08:49 AM, resident in her room by the bathroom ambulating holding on to a wheelchair, yelling for help.</p> <p>On 02/02/21 at 10:43 AM, concurrent observation with the DON found no FWW in R17's room. Interviewed the Physical Therapist (PT). The PT stated he was looking for the FWW as well, it has been missing for two days in a row, noticed it was missing since Friday (01/29/21).</p> <p>Review of R17's documented weight on 12/08/20, her weight was 118 pounds (lbs.) and after the fall on 12/18/20 documented R17 weight on 12/21/20</p>	F 689			

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F 689	Continued From page 13 was 111 lbs. R17 had a 6% weight loss within 13 days from 12/08/20 and 12/21/20. Interview with Registered Dietician (RD) on 02/01/21 at 12:59 PM, RD stated that she noticed resident also had a weight loss in July after a fall. RD further stated she thinks R17's refusal to eat is related to pain.	F 689			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, review of the facility's policy and procedures, and interview with staff member, the facility failed to ensure that all foods were procured, stored, prepared, distributed, and served under sanitary conditions. Three observations of a refrigerator found temperatures greater than 41 degrees Fahrenheit (F); stored food items were not covered; and expired dry	F 812			

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F 812	<p>Continued From page 14 good was not disposed.</p> <p>Findings Include:</p> <p>During the initial kitchen tour observation with Chef on 01/27/21 at 08:49 AM, the "Tray Setter Holding Fridge 2" inside thermometer measured 45 degrees F. Interview with Chef confirmed the measurement. Second observation on 02/01/21 at 07:45 AM found the inside thermometer measured 45 degrees F and the exterior thermometer measured 45 degrees F. Third observation on 02/02/21 at 12:15 PM, the inside thermometer measured 50 degrees F and the exterior thermometer measured 33.5 degrees F. During interview with Chef, "Temperature should be no higher than 41 degrees..." F.</p> <p>Observation during initial tour on 01/27/21 at 08:49 AM also found in the "Pantry Reach in Fridge" carrot sticks in a clear plastic container with lid slightly uncovered and tray of sliced and plated Tiramisu cake located in "Pantry Walk in Fridge" on a tray cart uncovered. The plastic that is on top of the tray cart was not completely over the cart. Chef acknowledged it should be covered.</p> <p>Observation on 02/02/21 at 12:15 PM of the dry goods storage, observed Kinoshita flour with written date 11/26/18. Interview with Chef, written dates are the day the goods were delivered, and the products are thrown out one year from delivery date. Chef stated the flour should have been thrown out.</p> <p>Review of facility's dining protocols under "Labeling Protocols" last revised on 04/2020, states "All non-perishable food will be stored in</p>	F 812			

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F 812	Continued From page 15 the storeroom and labeled with the date of receipt/delivery of items. Discard date is based on manufacturer recommendations and if none is available, then one year from date of receipt/delivery."	F 812			
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)  §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and interview with staff member, the facility failed to ensure the dishwasher is maintained in safe operating conditions. The facility did not have a system to ensure proper temperatures of the dishwasher was achieved.  Observation on 01/27/21 at 08:49 AM, while a dish test tray was going through the dishwasher, observed 2 out of 3 thermometers not reaching appropriate temperature. The thermometer for the wash function measured 140 degrees Fahrenheit (F) but indicated above the thermometer that it needs to reach 150 degrees F minimum. The thermometer for the rinse function measured 155 degrees F but indicated above the thermometer that it needs to reach 160 degrees F. Chef acknowledged "...something was wrong...".  Interview with Chef on 02/02/21 at 12:15 PM, stated on 01/27/21 the service company found the two thermometers were not working properly because there was a shortage in the wires.	F 908			



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F 908	Continued From page 16 Review of facility's dining protocols under "Sanitation" last revised on 12/07/16, states "Equipment used for...proper dishwashing shall be maintained in good working order."	F 908		

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E 000	<p>Initial Comments</p> <p>A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on 01/27/21 to 02/02/21.</p> <p>The facility met the Health Safety Requirements of Appendix "Z", for emergency preparedness and response; in accordance with 42 CFR 483.73 requirement for Long term care facilities.</p>	E 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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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K 000	INITIAL COMMENTS	K 000			
K 222 SS=F	<p>A Life Safety Code survey was conducted by Healthcare Management Solutions, LLC on behalf of the Department of Health, Office of Health Care Assurance on January 29, 2021. The Facility was found not to be in compliance with the requirements of 42 CFR 483.70 (a), 2012 Edition of the Life Safety Code for Long Term Care Facilities.</p> <p>Egress Doors CFR(s): NFPA 101</p> <p>Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a</p>	K 222			

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TITLE

(X6) DATE

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K 222	<p>Continued From page 1</p> <p>complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 <b>DELAYED-EGRESS LOCKING ARRANGEMENTS</b> Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 <b>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</b> Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 <b>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</b> Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that four of four exit doors met requirements for special locking arrangements. This deficient practice had the potential to affect all 71 residents who resided in the facility.</p>	K 222			

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K 222	Continued From page 2 NFPA 101 (2012 Edition) section 7.2.1.6, Special Locking Arrangements, Code 7.2.1.61.  Findings include:  Observations on 01/29/21 from 8:40 AM to 9:45 AM, of all four exit doors at the end of each corridor, revealed each exit door had continuous locking arrangements. The exit doors could only be opened with special knowledge or the use of a code on the keypad at each door. Interview with the Maintenance Director at the time of the observation revealed the doors would only open with the activation of the fire alarm and the keypad. Continued observation revealed the doors were also lacking signs of "keep pushing, doors will open in 15 seconds."  Under NFPA 101 Section 7.2.1.6.1, the code requires an "irreversible process shall release the lock in the direction of the egress within 15 seconds or 30 seconds upon application of the release device." In addition, the code also requires "a readily available durable sign in letter not less than 1 inch high and 1/8-inch-wide that reads, "Push Until Alarm Sounds, Door can be Opened in 15 Seconds."	K 222			
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101  Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	K 225			

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K 225	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure one of six stairway doors had a two-hour fire resistance rating. This deficient practice had the potential to affect all 71 residents who resided in the facility.  NFPA 101, Life Safety Code (2012 Edition), Section 7.2.3.3, Enclosure, Code 7.2.3.3.1.  Findings include:  Observations on 01/29/21 at 10:05 AM, revealed the stairway exit door near Physical Therapy lacked a fire rating tag. The door was located in a stairway communicating with 14 floors in the building and was labeled as an exit. During an interview with the Maintenance Director at the time of the observation, the Maintenance Director verified the door was lacking a rating tag. There were no marks on the door to show a missing label.  Under NFPA 101 section 7.2.3.3.1, the code requires "a smoke proof enclosure shall be continuously enclosed by barriers having a 2-hour fire resistance rating for the highest part to the exit discharge."	K 225			
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101  Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour.	K 311			

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K 311	<p>Continued From page 4</p> <p>An atrium may be used in accordance with 8.6.19.3.1.1 through 19.3.1.6</p> <p>If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure vertical openings were maintained for one elevator shaft and a mail depository. This deficient practice had the potential to affect all 71 residents who resided in the facility.</p> <p>NFPA 101 (2012 Edition) Section 8.6 to 8.5.2.2</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Observation on 01/29/21 at 10:00 AM of the fire wall at the elevator shaft on the third floor, revealed a two inch by two-inch hole above the ceiling tile. During an interview with the Maintenance Director at the time of the observation, the Maintenance Director verified the hole in the elevator wall.</li> </ol> <p>Under NFPA 101 (2012 edition) Section 8.6, the code requires that a two-hour separation must be maintained.</p> <ol style="list-style-type: none"> <li>2. Observation on 01/29/21 at 10:05 AM, of a mailbox system which communicated with 14 floors revealed a mail delivery system that had a four-inch slot on each floor. Mail was dropped by gravity into the slot and the mail would then proceed to the ground floor to an enclosed box. There was a hole on each floor. Interview with the Maintenance Director at the time of the</li> </ol>	K 311			

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K 311	Continued From page 5 observation revealed the mailbox system had been in the building since the building opened. The mailbox was plastic and ran vertically up the wall passing through all floors with metal mail slots.  Under NFPA 101 (2012 edition) Section 8.6 to 8.5.2.2, the code requires that smoke barriers are continuous from floor to floor.	K 311			
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101  Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to test the fire alarm system monthly; and failed to test all smoke detectors for smoke detection sensitivity. This deficient practice had the potential to affect all 71 residents who resided in the facility.  NFPA 101, Life Safety Code (2012 Edition), Section 19.7.1, Evacuation and Relocation Plan and Fire Drills, Code 19.7.1.4 and NPFA 72 table 14.4.2.2.  Findings include:  1. Review of the facility's fire drill records on	K 345			



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K 345	Continued From page 6 01/29/21 at 2:20 PM, revealed the facility did not test the fire alarm system in February 2020, May 2020, June 2020, July 2020, August 2020, September 2020, October 2020, November 2020, or December 2020. During an interview with the Maintenance Director, he stated, "we are doing in-services in small groups rather than conducting drills."  Under NFPA 101 section 19.7.1.4, the code requires that "fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions."  2. Review of the fire alarm reports on 01/29/21 at 2:40 PM, revealed a smoke detection test report dated 09/24/20. The report was lacking any ranges or readings of sensitivity for each detector, but simply indicated the device was tested. The facility had a self-monitoring smoke detection system; however, the facility could not access the system to provide evidence to the surveyor of status reports. Interview with the Maintenance Director at the time of the review revealed he did not know about the test and later indicated it was not done.  Under NFPA 72 table 14.4.2.2, the code requires that smoke detection sensitivity shall be completed every two years, and one year after a new detector is installed.	K 345			
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/29/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ARCADIA RETIREMENT RESIDENCE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1434 PUNAHOU STREET HONOLULU, HI 96822</b>		
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K 353	<p>Continued From page 7</p> <p>with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to test and maintain the sprinkler system quarterly and annually. This deficient practice had the potential to affect all 71 residents who resided in the facility.</p> <p>NFPA 25 table 5.1.1.2.</p> <p>Findings include:</p> <p>Review of the facility sprinkler system reports on 01/29/21 at 2:30 PM, revealed the facility had no quarterly or annual sprinkler system inspection for the past twelve months. Additionally, the Maintenance Director was completing the inspections himself without any credentials or knowledge of the requirements. There was no record of the supervisory signals or waterflow signals being checked for the past year. Interview with the Maintenance Director at the time of the record review revealed he had been completing</p>	K 353			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 353	Continued From page 8 the reports and confirmed he had no special training or knowledge that qualified him to conduct said inspections.  Under NFPA 25 table 5.1.1.2, the code requires that on a quarterly basis the waterflow device, alarm devices associated with the sprinkler system, the valve supervisory system devices need to be inspected. The annual inspections require bracing inspections, pipes and fittings and all sprinkler heads.	K 353			