STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125047	A. BUILDING _____ B. WING _____	01/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE OLA KINO	1314 KALAKAUA AVENUE, 2ND FLOOR HONOLULU, HI 96826

(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 A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 01/19/21 to 01/25/21. The facility was found not to be in substantial compliance with 42 CFR 483 Subpart B. Survey Dates: 01/19/21 to 01/25/21 Survey Census: 29 Sample Size: 8 Aspen Complaints/Incidents Tracking System (ACTS) complaint, #8472, was investigated during the survey and was found to be unsubstantiated.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 578		4/1/21

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

Electronically Signed | 02/15/2021

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F 578	Continued From page 1 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to establish a process with Resident (R)10 to ensure follow up with her advance directive. This deficient practice placed R10 at risk for an inability to refuse or receive medical or surgical treatment should she become incapacitated. Finding includes: R10 is an 88-year-old female admitted to the facility on 12/20/16 from an acute care hospital. She had diagnoses of multiple fractures sustained due to traumatic falls. A record review of R10's medical chart and electronic medical record found that she did not have an advance	F 578	* Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Upon learning of the deficient practice, the social services coordinator (SSC) reached out to the resident who then agreed to submit AHCD. The completed AHCD was subsequently filed into the physical and electronic chart. * Address how the facility will identify other residents having the potential to be affected by the same deficient practice;	

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F 578	Continued From page 2 directive. A review of R10's care plan initially dated 12/20/16 revealed no entry by staff indicating an objective for follow up with her advance directive. Further review of R10's medical record, social services (SS) notes dated 01/05/17 to 12/17/20, revealed no documentation of any discussions between SS and R10 or any discussions during care plan meetings about formulating an advance directive (refer F842). A SS note documented on 01/21/21 at 10:55 AM revealed, "SSC (social services) asked One K (independent living area where R10 previously resided) RCS if the [sic] send resident's AHCD (advanced health care directive). RCS acknowledged and will send one over after checking resident's file." An interview was done with SS on 01/25/21 at 09:53 AM in the staff break room. He stated that his duty for advanced care planning on the resident's admission to the facility is to "look for the resident's POLST (provider orders for life sustaining treatment) and AHCD" and "discuss their goals." SS stated that he had discussions with R10 about her advance directive and did not document this in R10's medical record because she was still able to make her own decisions and would refuse to file an advance directive (refer to F842) A review of the facility's AHCD Standard Operating Procedure revised on 11/01 stated, "...Social Services will follow up with those residents who do not have advance health care directives and offer assistance to formulate any documents that the resident desires ...The interdisciplinary team will review, at a minimum, annually with the resident/responsible party his or	F 578	The SSC (in conjunction with the medical records professional) conducted an audit of the residents in the community who may have the potential to be affected by the same deficient practice. They found no other residents to have been affected. * Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; SSC will educate the resident (resident representative) upon admission as it relates to AHCD including completing the admission checklist and assessment. SSC will then review again at the quarterly careplan meetings and document in the EHR. Medical records professional will conduct an admission chart audit and report any missing AHCD and/or missing progress notes as it pertains to this topic. * Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system; Initially and for the next 30 days, the audit checklist/report shall be reviewed by the administrator to ensure compliance. The SSC and the Medical records professional shall develop a QAPI on this issue and be	

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F 578	Continued From page 3 her advance health care directives to ensure that they are still the wishes of the resident. This information will be documented in the social services notes section of the medical record." The deficient practices of lacking a plan to formulate an advance directive and lacking documentation of services provided, resulted in an untimely follow up of the resident's advance directive. This placed the resident at risk for the inability to refuse or receive medical or surgical treatment should the resident become incapacitated.	F 578	responsible for ongoing audits to ensure compliance. These findings (and any additional corrective actions) will be reported at the quarterly quality assurance/process improvement meetings. * Dates when corrective action will be completed. April 1	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842		4/1/21

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F 842	Continued From page 4	F 842		

regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed

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F 842	Continued From page 5 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to document interactions with Resident (R)10 regarding follow up with her advance directive. This deficient practice failed to accurately portray social services (SS) provided to R10. This also places R10 at risk for an inability to refuse or receive medical or surgical treatment should she becomes incapacitated. Finding includes: R10 is an 88-year-old female admitted to the facility on 12/20/16 from an acute care hospital. She had diagnoses of multiple fractures sustained due to traumatic falls. A record review of R10's medical chart and electronic medical record found that she did not have an advance directive. A review of R10's care plan initially dated 12/20/16 revealed no entry by the staff indicating an objective for a follow up with her advance directive. Further review of R10's medical record, SS notes dated 01/05/17 to 12/17/20, revealed no documentation of any discussions between SS and R10 or any discussions made during care plan meetings about her advance directive. An interview was done with SS on 01/25/21 at 09:53 AM in the staff break room. He stated that his duty for advanced care planning on the resident's admission to the facility is to "look for the resident's POLST (provider orders for life sustaining treatment) and AHCD (advance health care directive)" and "discuss their goals." SS	F 842	" Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Upon learning of the deficient practice, medical records professional (MR) queried the social services coordinator (SSC) if a copy of the advance directives has been obtained by the resident representative, and if not, is there charting to support it. It was confirmed that the deficient practice had been corrected. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The SSC (in conjunction with the medical records professional) conducted an audit of the residents in the community who may have the potential to be affected by the same deficient practice. The SSC and MR found no other residents to have been affected " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Medical records worker will conduct an admission audit on every admission and report any missing advance directive	

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F 842	Continued From page 6 stated that he had discussions with R10 about her advance directive and did not document this in R10's medical record because she was still able to make her own decisions and would refuse to file an advance directive. A review of the facility's AHCD Standard Operating Procedure revised on 11/01 stated, "...Social Services will follow up with those residents who do not have advance health care directives and offer assistance to formulate any documents that the resident desires ...The interdisciplinary team will review, at a minimum, annually with the resident/responsible party his or her advance health care directives to ensure that they are still the wishes of the resident. This information will be documented in the social services notes section of the medical record." The deficient practices of lacking a plan to formulate an advance directive and lacking documentation of SS services provided, resulted in an untimely follow up of the resident's advance directive. This placed the resident at risk for the inability to refuse or receive medical or surgical treatment should the resident become incapacitated.	F 842	documents and/or missing progress notes in the EHR as it pertains to advance directives. The admission audits will be reviewed by the administrator for the next 30 days to ensure compliance. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system; and The Medical records professional shall undergo ongoing audits to ensure compliance and incorporate into the community□s quarterly QAPI. These findings (and any additional corrective actions) will be reported at the quarterly quality assurance/process improvement meetings. " Dates when corrective action will be completed. April 1	
F 880 SS=D	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.	F 880		4/1/21

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F 880	Continued From page 7 §483.80(a) Infection prevention and control 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	F 880		

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F 880	Continued From page 8 disease or infected skin lesions from direct contact with residents or their food, if direct 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 observation and interview, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment to help prevent the transmission of communicable disease and infection. This deficient practice has the potential to affect the remaining 30 residents in the facility and future admissions. Findings include: During a concurrent observation and interview of medication administration on 01/25/21 at 8:45 AM, surveyor queried licensed nurse (LN)1 regarding Point of Care testing (POC) for blood glucose machine. LN1 verbalized he cleans the machine with PDI Sani-Cloth germicidal wipe. Queried LPN1 what is the recommended contact	F 880	* Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice -Upon learning of the deficient practice, licensed nurse in question received and completed re-training on the contact time for PDI Sani-cloth germicidal wipe. This was completed on 1/29/21. * Address how the facility will identify other residents having the potential to be affected by the same deficient practice; -There are 2 glucose monitoring machines alternately used for blood glucose monitoring for the facility. After each machine is used, it is wiped down	

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F 880	Continued From page 9 time for the germicidal wipe is. LN1 stated he did not know. Germicidal wipe packet was reviewed with LN1. LN1 noted the four-minute contact time for effectiveness of the wipe.	F 880	with the PDI Sani-cloth germicidal wipe and set aside for contact time. During the time of survey- there was only 1 resident requiring accucheck procedure. NO other resident(s)affected. * Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. -Licensed nurses will undergo re-training on Hale Ola Kino□'s Glucose monitoring Policy and Procedure and contact time of the PDI Sani-cloth Germicidal Wipe. -All Licensed staff will complete the training videos and submit attendance sheet using this website: Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig -All Licensed staff will complete the CMS Nursing Home Infection Preventionist Training Course, Point-of Care Blood Testing, Module 10D. All training documents will be completed and submitted to OHCA by 3/22/2021. * Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system; -Licensed staff monthly competency testing on glucose monitoring procedure	

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F 880	Continued From page 10	F 880	will be conducted for 3 consecutive months. -Root Cause Analysis (RCA) will be done with assistance from the Infection Preventionist, Quality Assurance & Performance Improvement committee and Governing Body. This RCA will be incorporated in the facility□'s infection prevention program and will be included with the facility'□s quarterly QAPI. * Dates when corrective action will be completed. -Training and Courses will be completed by March 22, 2021 -Competency on Glucose monitoring procedures will be completed by April 1, 2021	

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E 000	Initial Comments The facility was found to be in compliance with Section 483.73, Requirement for Long Term Care (LTC) Facility Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual.	E 000		

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

Electronically Signed | 02/15/2021

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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	125047	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2021**

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K 000	INITIAL COMMENTS 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 27, 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.	K 000		
K 225 SS=E	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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure one of two stairway doors had a two-hour fire rating. This deficient practice had the potential to affect 13 residents in one smoke zone. NFPA 101, Life Safety Code (2012 Edition), Section 7.2.3.3, Enclosure, Code 7.2.3.3.1. Findings include: Observations on 01/27/21 at 3:00 PM revealed the stairway exit door near bedroom #206 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. Interview with	K 225	* Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Upon learning of the deficient practice, One Kalakaua Senior Living building management requested a bid/price quotes from 3 reputable companies to assess and determine whether the door will be replaced and/or be re-certified with an appropriate and proper fire rating tag. All three contractors are certified and licensed to follow and adhere to the fire code regulations and will ensure NFPA 101, Life Safety Code (2012 Edition),	5/15/21

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

Electronically Signed | 02/15/2021

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	125047	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE OLA KINO	**1314 KALAKAUA AVENUE, 2ND FLOOR** **HONOLULU, HI 96826**

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K 225	Continued From page 1 the Administrator at the time of the observation revealed the door was the same door originally installed. 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	Section 7.2.3.3., Enclosure, Code 7.2.3.3.1 will be met. Price quotes will be acquired by February 19, 2021. * Address how the facility will identify other residents having the potential to be affected by the same deficient practice; One Kalakaua Senior building manager reviewed and audited all doors in the health center and did not find any other doors missing their fire rating tag. * Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Once the bids have all been received, One Kalakaua building management will select the winning contractor to complete the project and sign the winning bid no later than February 26, 2021. If the option is to replace the fire-rated door, the lead time for when it will arrive on island is at least 6-12 weeks from the date it is ordered. Once the door is confirmed on island, One Kalakaua will schedule with the contractor to install and recertify the fire door no later than May 15, 2021. * Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of	

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K 225	Continued From page 2	K 225	correction is integrated into the quality assurance system; Annual door inspections will be conducted for all fire-rated doors to include documenting missing fire-rated door tags and will document all findings in the Life Safety Binder. Any door found to be out of compliance, One Kalakaua building management will contract with an appropriate, certified organization to bring fire-rated door back into compliance. * Dates when corrective action will be completed. May 15, 2021	
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 observation and interview, the facility failed to ensure that smoke detectors were not too close to air diffusers; and smoke detection sensitivity tests had been completed within two years. This deficient practice had the potential to affect all 26 residents who resided in the facility. NFPA 72 (2010) Edition section 17.7.6.3.2 and	K 345	1. Smoke Detectors * Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Upon learning of the deficient practice,	3/29/21

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K 345	Continued From page 3 table 14.4.2.2. Findings include: 1. Observations on 01/27/21 from 2:10 PM to 2:30 PM of smoke detectors in bedrooms #251, #249, #245, #216, #214, #212, #210, #208, #220, #223, #225, #227, and the business office revealed all smoke detectors were within one foot of a ceiling air diffuser. Interview with the Administrator at the time of the observation revealed the smoke detectors were installed that way 20 years ago. Under NFPA 72 Section 17.7.6.3.2, the code requires that "smoke detectors will not be located directly on the air stream of supply registers. 2. Review of the fire alarm reports on 01/27/21 at 3:15 PM revealed two smoke detection test report dates of 06/25/20 and 07/01/19. The reports were lacking any ranges or readings of the sensitivity for each detector. Interview with the Operations Manager at the time of the review revealed she was not aware of the requirement that sensitivity testing needed to be completed. 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	One Kalakaua Senior Living building management consulted with their contracted fire alarm company, In Control, to establish a plan to bring the building back into compliance. This plan includes assessing each room where the smoke detectors are not in compliance and determine materials and labor needed to properly relocate them. Price quotes for this project will be acquired by February 19, 2021. * Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Upon learning of the deficient practice, all other rooms were assessed and found the Makai shower room to be out of compliance and has been added to the list for relocation. * Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On February 25, 2021, One K will attempt to relocate the diffusers away from direct airstream of the smoke detectors to meet NFPA 72 compliance. What diffusers cannot be relocated, In Control will be scheduled to relocate and/or replace the smoke detectors to comply with NFPA 72 (2010 edition). * Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must	

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K 345	Continued From page 4	K 345	develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system; One Kalakaua Senior Living building management shall conduct annual inspections to ensure the code NFPA 72 Section 17.7.6.3.2 is maintained and that smoke detectors shall remain on the outside of the direct airflow from those registers. This annual report will be placed in the Life Safety binder and appear in the quarterly quality assurance/process improvement meeting minutes to ensure sustained, corrective action. * Dates when corrective action will be completed. March 29, 2021 2. Sensitivity Report * Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Upon learning of the deficient practice, One Kalakaua Senior Living building management consulted with their contracted fire alarm company, In Control, to establish a plan to bring the building back into compliance. Price quotes for	

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K 345	Continued From page 5	K 345	this project will be acquired by February 12, 2021. * Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Upon learning of the deficient practice, additional research was conducted as to why there was no sensitivity report. The fire detection system, Simplex 4100 operator□s manual indicates that it meets the sensitivity requirement as it continuously monitors all building□s smoke detectors. When they are out of range based on NFPA 72 14.4.3.2, the fire panel alerts the building management to assess and correct. As noted on the attached sample 2020 fire drill log, there were smoke detectors that were outside of the sensitivity rating and were assessed and placed back into compliance. Using the 4100 LCD and the display/action keys, the control panel can display various status conditions for each TrueAlarm sensor, the sensor□s present selected sensitivity level as a percent of obscuration per foot. This selected sensitivity level is the value at which the FIP will cause an alarm condition. Seven (7) sensitivity levels are available for the TrueAlarm photoelectric sensor. The most sensitive setting is 0.2% OBS/FT (0.5% OBS/M) with the least sensitive setting being 3.7% OBS/FT (11.5% OBS/M). That being said, One Kalakaua building management has contracted with	

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K 345	Continued From page 6	K 345	InControl to produce a sensitivity report for the purposes of meeting and exceeding this compliance regulation. * Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; InControl has been contracted to create a sensitivity report that will meet the NFPA 72 table 14.4.2.2. code requirements and present to One Kalakaua building management. * Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system; One Kalakaua Senior Living building management shall ensure the smoke detection sensitivity report be completed every two years, and one year after a new detector is installed and include in the health center□s life safety binder as required under NFPA 72 Section 17.7.6.3.2. * Dates when corrective action will be completed. March 29, 2021	