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F 000	INITIAL COMMENTS A re-certification survey was conducted by the Office of Health Care Assurance (OHCA) on 03/02/21 - 03/05/21. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/02/21 - 03/05/21 Survey Census: 43 Sample Size: 13 Supplemental Residents: None. There also were no facility reported incidents to review.	F 000		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757		

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

Electronically Signed

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stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview with staff member, the facility did not ensure 1 of 5 residents selected for medication review was not provided with multiple medications for pain. Resident (R)1 is prescribed with three medications for pain with no indications for use.

Findings Include:

Resident (R)1 was admitted to the facility on 05/18/20 with the following diagnoses: hemiplegia and hemiparesis and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side; cerebral infarction; vascular dementia without behavioral disturbance; dysphagia following cerebrovascular disease; Type 2 diabetes mellitus without complications; and major depressive disorder recurrent unspecified.

Record review on 03/03/21 at 07:33 PM found physician order for three medications to manage R1's pain: 1) percocet tablet, 5-325 mg, give one tablet every six hours as needed for pain; 2) ibuprofen 200 mg, give three tablets by mouth every 6 hours as needed for pain; and 3) acetaminophen tablet 325 mg. give two tablets by mouth every 4 hours as needed for pain.

A review of the Medication Administration Record (MAR) for February 2021 notes percocet and tylenol were administered in response to pain levels ranging from 2 to 5. Ibuprofen was administered for pain levels ranging from 4 to 6. Further review found administration of tylenol was

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F 757	Continued From page 2 ineffective on the following days: 02/07/21 at 0930 AM (pain level of 5); 02/09/21 at 03:39 PM (pain level of 2) and 02/15/21 at 06:11 PM (pain level of 4). Also noted on 02/03/21 tylenol, percocet and ibuprofen were administered, Tylenol was administered at 03:33 PM (pain level of 4, effective), percocet at 09:10 PM (pain level of 4, effective) and ibuprofen at 06:15 PM (pain level of 4, effective). R1 was also provided with two medications for pain, tylenol and percocet on the following days: 02/09/21, 02/15/21, 02/18/21, and 02/25/21. Interview was done with the Director of Nursing Services (DNS) on 03/05/21 at 09:16 AM. DNS reported R1 oftentimes has psychosomatic pain. DNS further reported resident was anxious about receiving the COVID-19 vaccine and provided with medication for anxiety. DNS also noted R1 has migraines and shoulder pain. A topical ointment is provided for shoulder pain. Queried how does staff know which prn pain medication to administer as R1 has three medications for pain. DNS responded the ibuprofen is usually used for shoulder pain. Further queried, how staff determine whether to administer tylenol or percocet as the MAR documents there are varying pain levels for the use of both medications. DNS acknowledged that there are no parameters in the orders to determine which pain medication should be administered, for example, based on level of pain, type of pain (migraine vs. muscle ache).	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		

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affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

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§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview with staff member, the facility failed to ensure 1 (Resident 1) of 5 residents selected for unnecessary medication review did not have prn (pro ro nata - as needed) order for psychotropic medication that was not limited to 14 days. The prn order for an anti-anxiety medication (hydroxyzine) exceeded the 14 day limitation without documentation of the rationale for the extension. Also, there is no documentation for the duration of the prn order.

Findings Include:

Resident (R)1 was admitted to the facility on 05/18/20 with a diagnoses of major depressive disorder recurrent unspecified and vascular dementia without behavioral disturbance.

Record review on 03/03/21 at 07:33 PM and 03/04/21 at 08:48 AM found physician orders for which include, hydroxyzine HCl tablet 10 mg, give 5 mg every 6 hours as needed for itching/anxiety prn. The start date of the order is 01/04/21. Hydroxyzine is used to treat allergies and anxiety. A review of the Medication Administration Record (MAR) notes to "monitor for indicators of anxiety as evidenced by (specify)". There are no identified specified indicators of anxiety.

The MAR documents prn administration of hydroxyzine on the following dates: 02/01/21,

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02/04/21, 02/14/21, 02/19/21, 02/20/21, 02/24/21 and twice on 02/26/21. Also noted, R1 is being monitored for indicators of anxiety. The MAR indicates on 02/01/21 the resident had four episodes of anxiety, a prn was administered at 10:23 AM. Further review notes no indicators of anxiety on the dates that a prn was administered. The record review found no documentation of a rationale to continue R1's order for an anti-anxiety medication that exceeded the 14-day limitation.

R1 also receives routine administration of an antidepressant, duloxetine (30 mg) twice a day. A noted side effect of duloxetine is anxiety. A review of the care plan addresses the use of antidepressant with pharmacological and non-pharmacological interventions. There was no care plan to address R1's anxiety.

On 03/05/21 at 09:16 interview and concurrent record review was done with the Director of Nursing Services (DNS). Inquired whether R1's physician has documentation for continued use of anti-anxiety medication exceeding 14 days. DNS could not find documentation in the electronic medical record of a physician's rationale for extending the prn order. Also, there was no documentation by the pharmacist regarding the physician's order exceeding the 14-day limit. The DNS reported R1 was anxious regarding administration of COVID-19 vaccination and now presenting with a sore throat.

The DNS provided further documentation from the facility's Doctorate Nurse Practitioner (DNP) on 03/10/21. The DNP's documentation was reviewed on the morning of 03/16/21. The DNP's progress notes for 11/10/20, 12/14/20, 12/21/20, 02/17/21 and 03/05/21 documents under the

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F 758	Continued From page 6 heading of Depression/Anxiety to begin "hydralazine" 50 mg po daily and 50 mg as needed . Also, to continue cymbalta (duloxetine). On 03/15/21 at 10:06 AM, a telephone interview was conducted with the DNS. The DNS made reference to the DNP's notes under the heading of Depression/Anxiety. DNS confirmed that the psychotropic medication orders were listed. Further queried whether the DNP provided a rationale for continuing the prn order surpassing the 14-day limitation. In addition to the rationale for extension, identification of duration of the order. The DNS confirmed there is no documentation for the rationale for continued use and duration of the order. Of note, the DNP lists hydralazine (vasodilator to treat high blood pressure) not hydroxyzine under caption of Depression/Anxiety.	F 758		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-	F 801		

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(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or

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(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that the designated director of food and nutrition services had the appropriate competencies and skills sets to carry out the functions of the position. Specifically, the facility failed to employ a Dietary Manager who was a clinically qualified nutrition professional, held any dietary or food service certifications, or who held a degree related to food service. It is essential for the director of food and nutrition services to have the knowledge, training, and abilities to develop, promote, evaluate and modify a food and nutrition program that adheres to national safety standards, and meets the needs of the residents. This deficient practice has the potential to compromise the health and nutritional status of all residents at the facility.

Findings Include:

1) On 03/02/21 at 12:21 PM, an interview and

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F 801	Continued From page 9 initial tour of the kitchen was done with the Dietary Manager (FSM), and the Admissions Coordinator (AC), who is also the former FSM. The FSM stated she has held the position for less than a year and moved over from Staffing and Central Supply. The FSM receives her training from the Registered Dietician (RD), who is at the facility once a week. It was noted during the tour of the kitchen that the FSM could not answer many basic questions such as where the thermometer in the walk-in fridge was located, what temperature the refrigerators should be held at, or what the food labeling and food storage procedures were. 2) On 03/05/21 at 08:35 AM, an interview was done with AC in the Laulima Conference Room. When asked about FSM's qualifications and trainings, AC explained that FSM has previous experience working in restaurants, but has no formal food service education, training, or certifications. 3) A review of FSM's training documents notes one certificate of completion, dated 09/10/2020, for the "eFoodHandler Basic Safety Course Hawaii Version".	F 801		
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	F 812		

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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 observation, interview, and record review, the facility failed to store, label, prepare, monitor, and discard food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure all perishable or refrigerated food items and beverages were labeled, dated, and monitored, failed to verify food temperatures using a thermometer that was sanitized and calibrated, and failed to ensure the dishwashing system being used was maintained at the concentration levels recommended by the manufacturer for proper sanitization. Residents (R) risk serious complications from foodborne illness as a result of their compromised health status. Unsafe and/or unsanitary food handling practices represent a potential source of pathogen exposure for all residents at the facility.

Findings Include:

1) On 03/02/21 at 12:21 PM, a tour of the kitchen (K) was done with the Dietary Manager (FSM), the Admissions Coordinator (AC), and the Kitchen Staff (KS) 1. The tour began with observations made in the dry storage room. A large unlabeled

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bag of crispy rice cereal was observed on one of the wire shelves. The bag had been opened, then wrapped in saran wrap, and placed back on the shelf. There was no visible indication as to when the bag had been received or opened. AC acknowledged that the bag should have been labeled when it was opened.

2) On 03/02/21 at approximately 12:30 PM, the tour of the K continued over to the dishwasher. An interview with KS1 was done at this time, and she stated that all cooks and kitchen helpers were responsible for dishwashing, including herself. During the interview, and despite having just washed the breakfast dishes, KS1 was unable to explain or demonstrate the process of testing the concentration level of the sanitizing solution in the dishwasher. KS1 could not verbalize which test strips to use, the correct concentration level (or even color) to look for on the strip, how long after dipping the test strip can it be read, how often the solution should be monitored, or where to document the concentration levels.

3) On 03/02/21 at approximately 12:40 PM, the tour of the K continued over to the walk-in fridge. An interview with FSM at the time determined that she was unaware of where in the fridge the thermometer was located, or what the fridge temperature should be. While inspecting the contents of the walk-in fridge, a three-pound tub of Daisy sour cream with a product expiration date of 02/15/21 and labeled opened on 01/03/21 was found. When asked, both FSM and AC say that sour cream is usually good for 30 days after opening. A review of the facility's Food Storage Policy and Procedure, last revised on 01/17/06, notes sour cream is only good for one to two

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weeks. A disposable storage container with pineapple tidbits, labeled "Use By: 2-27-21" was also found, in addition to seven whole eggs sitting in an uncovered, unlabeled, bowl on the bottom of the wire shelving. Both FSM and AC acknowledged that the eggs should have been labeled. Numerous opened items were found that were either unlabeled, or had a date written on in black sharpie. It was unclear to all present whether the dates written were the dates received, or the dates opened. These items included a large jar of mayonnaise, a bottle of hot chili sauce, a tub of miso paste, a bottle of barbeque sauce, and a bottle of salad dressing. FSM agreed that it is important to label all perishable items to ensure they can be safely used for consumption.

4) On 03/05/21 at 09:00 AM, an inspection of the dining room refrigerators was conducted. A carton of Ready Care honey consistency orange juice, dated as opened on 3/2/21, with a product use by date of 12/18/20, was found in the Laulima Dining Room fridge. Three bottles of Ensure Clear mixed berry juice with a product expiration of 2/1/21 was found in the Lokahi Dining Room fridge. The K was re-checked at this time, and three more cartons of honey consistency orange juice with product use by dates of 12/18/20 were found on the top shelf in the dry food storage room, alongside one carton of nectar consistency orange juice with a product use by date of 3/2/21. There was no further stock of these items noted in the storage room.

5) On 03/05/21 at 09:30 AM, an interview was done in the K with KS1 and FSM. They were asked to demonstrate how the food temperatures were taken on the tray line. Per the K staff, one

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F 812	Continued From page 13 thermometer is used to check every dish on the tray line. In between dishes, the thermometer is wiped with a Fresh Nap moist towelette (for hands, "napkin size towelette saturated with a pleasantly scented cleansing lotion"), dipped in a cup of ice water, then dipped in the next dish on the line "for three seconds", before the temperature is read and documented on the log. None of the staff present could describe how the thermometer is calibrated, nor was anyone aware when it was last calibrated. These deficient practices make it clear that there is no system in place to ensure that safe and sanitary food handling practices are consistently implemented in order to minimize the risk of food-borne illnesses.	F 812		
F 880 SS=F	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. §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	F 880		

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	125061	A. BUILDING _____ B. WING _____	03/05/2021

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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 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.

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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 observations and interviews with staff member, the facility failed to implement appropriate hand hygiene and use of personal protective equipment for a resident on droplet/contact precautions, and failed to to ensure COVID-19 screening temperatures for their employees, visitors, and vendors was observed by staff at the designated point of screening/entry. There also was a potential for the face masks to be contaminated as it was left out in the open for individuals to grab and sustain water splash as well. 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.

Findings Include:

1) Resident (R)8 was admitted to the facility on 12/04/19 and receives hemodialysis three times a week at a dialysis facility. On the morning of 03/02/21 observed signage, "Special Droplet/Contact Precautions" posted outside of R8's room. It was highlighted for "Only essential personnel should enter this room". The instructions include: clean hands when entering and leaving room; wear face mask; wear eye protection (face shield or goggles); gown and glove at door; when doing aerosolizing

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procedures fit tested N-95 with eye protection or higher is required; keep door closed; and use patient dedicated or disposable equipment, clean and disinfect shared equipment.

On 03/03/21 at 01:06 PM interviewed Registered Nurse (RN)2 regarding personal protective equipment (PPE) required before entering R8's room. RN2 explained the resident is on modified transmission based precautions. RN2 instructed to change face mask before entering, don gloves, gown and face shield. RN2 provided instructions to remove gloves and gown, change face mask and sanitize face shield when leaving the resident's room.

R8 was interviewed in the room. Upon exit, there was no receptacle to dispose of the glove and gowns in the resident's room. There was a spray bottle on the cart which housed the clean supplies (face mask, gloves) to sanitize the face shield; however, there was no place to place the face shield down to spray/sanitize it. There was a small trash receptacle with a lid and labeled, "Safety Glasses", no receptacle outside to dispose of gown and gloves. Observed two female residents sitting next to the resident's door.

On 03/03/21 at 12:15 PM observed Activity Aide (AA)1 enter R8's room, AA1 had a face mask and face shield on (did not hand sanitize and don gown, gloves and change face mask). AA1 was heard asking R8 if he needed anything. Upon exit, AA1 did not hand sanitize, change face mask and sanitize face shield. At 01:20 PM interviewed AA1 regarding use of PPE, AA1 acknowledged not following the procedures for using PPE.

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On 03/03/21 at 02:39 PM observed Certified Nurse Aide (CNA)1 enter R8's room asking if he would like a snack. CNA1 entered the room wearing a face mask and face shield, hand sanitizing was not observed. Upon exiting, did not hand sanitize, walked over to the snack cart, picked up a snack and re-entered R8's room, wearing face mask and face shield. Interviewed CNA1 and inquired whether she followed the procedures for entering and exiting R8's room. CNA1 reported that she washed her hands before entering. Further queried what needs to be done before entering the resident's room. CNA1 replied, they need to put goggles on and proceeds to open a drawer and removes goggles and a brown paper bag. Reminded CNA1 that she did not hand sanitize and was touching equipment on the clean cart. CNA1 threw away the bags and goggles, mistakenly dropping her glasses in the small receptacle labeled safety glasses. CNA1 donned gloves (no hand sanitizing observed prior to donning gloves). Inquired whether she followed the procedures for PPE, CNA responded affirmatively. Further queried what are the procedures, CNA1 replied, put on goggles, glove and gown. CNA1 was asked whether she put on goggles, glove and gown, she replied "no".

The Director of Nursing Services (DNS) was interviewed on 03/03/21 at 03:05 PM. DNS explained R8 leaves the facility for dialysis and is on a modified precaution which requires the resident to wear a face mask when not in his room. The DNS reported there is a red receptacle by the curtain in R8's bathroom (there is a curtain across the bathroom for resident's privacy). Staff members also store reusable PPE

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in the resident's room, there are hooks on the door for that purpose. DNS explained prior to entering the room, staff members perform hand hygiene and prior to exiting the room, doff PPE (store in the resident's room) and at the end of their shift dispose of reusable PPE.

Observations were shared with the DNS, DNS confirmed staff members are required to don gloves, gown, wear a face shield and change face mask when entering R8's room. If this is a one time visit, PPEs are disposed inside the resident's room. Upon exit, staff members are required to change face mask and sanitize face shield. DNS acknowledged infection control breech by staff members. In addition, DNS reported she will do an in-service now.

2) On 03/02/21 at 10:22 AM, the State survey agency (SA) team arrived at the facility to begin the survey. The SA team was informed by a facility staff nurse (RN1), "take your own temperature." RN1 was inside of the building and the SA was told to do this through the screen window next to the entry door.

The SA observed to the right of the entrance, the area to "take your own temperature" had a sink with a small countertop. Hand washing soap was available and a paper towel dispenser was above the sink. Right next to the sink, there was a box of blue procedure masks in a white rack, and it was next to the soap dispenser. The top of the box containing the face masks was left open, exposing the face masks to potential water splash when people washed their hands, and/or touching more than one mask at a time. The RN1 was not able to see if an individual touched or grabbed a mask before handwashing as well. Below the rack was a box of medium alcohol prep

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pads (200 count). Then there was a white contactless thermometer in a small round black rack next to the face masks.

The instructions for the facility's screening process included the following:
1. Perform hand hygiene at sink
2. Check temperature and complete screening form
(In red type, it further stated at no. 2 in bold type, "You are not to enter the facility if you have a temperature greater than 99.0 degrees", then in black type below it, "Disinfect thermometer AND pen with alcohol swab after use before placing back into holder"
3. Don facemask and insert screening form thru door slot
4. Ring doorbell
5. Sanitize hands with hand sanitizer
6. Once entry authorized, you will be provided a screening clearance sticker
7. If you begin to feel ill during your shift, notify your supervisor immediately

However, although the SA followed the instructions as posted, the RN1 was not physically able to see and verify that the temperatures were being taken and that the thermometer was being effectively cleaned with the small alcohol prep pads. Also because of the water splash onto the small countertop, even though handwashing was initially done, the water had to be wiped up before filling out the appropriate screening form.

The SA asked RN1 who was sitting inside the building by a screened window, how she could actually verify what the surveyor's temperature was since she was inside the building and could

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F 880	Continued From page 20 not see what the temperature was taken at. RN1 paused and said, "Oh yes, I think we can improve." Then RN1 said, "I'll take your temperature." On 03/05/21 at 09:55 AM, an interview with the Director of Nursing Services (DNS) was done. The DNS stated RN1 thought that since it was a survey and being medical professionals, there was some confusion as to how the forms (i.e., employee forms versus visitor forms) were to be done, and that visitors "don't take their own temperatures." She acknowledged wanting to change the order of their screening process and to move the mask storage above the hand sanitizer to eliminate splash, and other measures. The DNS verified that RN1 was not let have let visitors take their own temperature and walk up the ramp (to the doorway entrance) as well.	F 880		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility is free of flies. According to the Centers for Disease Control and Prevention (CDC), insects can serve as agents for the mechanical transmission of microorganisms, or as active participants in the disease transmission process by serving as a vector. This deficient practice exposes all the residents at the facility to potential disease transmission.	F 925		

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F 925	Continued From page 21	F 925		

Findings Include:

1) On 03/02/21 at 12:29 PM, an observation was made while interviewing the Dietary Manager (FSM) in the kitchen (K). A large, black fly was observed flying around the ice machine as the FSM opened it for inspection. A large, black fly was also observed eleven minutes later, further in the K, flying around the dry bulk storage bins.

2) Numerous other observations of flies were made on 03/03/21 at 09:51 AM, near the Laulima (L) nurses station/medication cart, on 03/03/21 at 09:59 AM, near medication cups holding crushed medication mixed with pudding for resident (R) 25 in the Laulima Day Room (LDR), on 03/03/21 at 11:42 AM, near R6 who was still eating his breakfast in the LDR, on 03/03/21 at 11:57 AM, near the lunch tray of R13 in her room in the L building, on 03/05/21 at 09:55 AM, near residents sitting in the LDR, and on 03/05/21 at 10:48 AM, near residents playing cards in the Laulima Dining Room (LGR).

3) On 03/04/21 at 09:27 AM, an interview was done with the Maintenance Director (MD) in the Laulima Conference Room (LCR). MD said the facility contracts out to Ecolab for pest control, who provide on-site services once a month. The Pest Control Program currently includes interior treatments, such as glue traps for large flies, and exterior treatments for centipedes, termites, and other pests. The facility participates in Ecolab's Large Fly Program, which includes four Stealth LED Fly Lights (glue traps), one each in the LGR and Lokahi Dining Room (which due to COVID are not being used for dining), one in the LCR, and one in the K. The glue traps in the Stealth

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F 925	Continued From page 22 LED Fly Lights are changed out once a month. MD unable to produce any product information for the Fly Lights. 4) A review of Ecolab's website notes that the Ecolab Stealth LED Fly Light "can attract flies up to 12 feet away at any angle where view of the light is not blocked by another object(s)." 5) On 03/05/21 at 10:40 AM, another interview was done with MD in the LGR. MD confirmed that each Fly Light was installed at least twelve feet above the ground, and that the Fly Light in the K was installed in a spot around a corner, with a wall that separates it from all the food prep and food storage areas of the K. MD agreed that the flies are a problem, especially in the K, and stated that the facility needs more Fly Lights, as well as to plan and implement additional measures for fly control.	F 925		

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E 000	Initial Comments The facility was found in compliance with Section 483.73, Requirement for Long-Term Care (LTC) Facilities of Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual, during the recertification survey conducted by the Office of Health Care Assurance (OHCA) from 03/02/21 - 03/05/21.	E 000		

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

Electronically Signed

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 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 03/25/21. 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 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the means of egress free of all obstructions. This had the potential to affect all 42 residents who resided in the facility. NFPA 101 (2012 edition) section 19.2.2.2.5. Findings include: Observation on 03/25/21 at 9:05 AM revealed a locked means of egress gate on the exterior section of the Laulima building affecting the exit near bedroom #4. The gate had a lock requiring a key. In addition, a chain was wrapped around the gate preventing it from being opened. The gate provided a means of egress via a sidewalk to the public way.	K 211		

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K 211	Continued From page 1 Observation on 03/25/21 at 9:15 AM revealed a locked means of egress gate on the exterior section of the Laulima building affecting the exit near bedroom #11. The gate had a lock requiring a key. In addition, a chain was wrapped around the gate preventing it from being opened. The gate provided a means of egress via a sidewalk to the public way. Observation on 03/25/21 at 9:20 AM revealed a locked means of egress gate on the exterior section of the Laulima building affecting the exit near the dining room. The gate had a lock requiring a key to access. In addition, a chain was wrapped around the gate preventing it from being opened. The gate provided a means of egress via a sidewalk to the public way. Observation on 03/25/21 at 10:00 AM of an interior exit door in the main dining room in the Laulima Building revealed the doorknob contained a locking device that required a person to have good dexterity to turn the small knob and unlock the door. The door locking device was in the locked position at the time of the observation. An exit sign was located above the door. The floor plan located on the wall revealed the door was designated as an exit. Observation on 03/25/21 at 10:05 AM revealed a locked means of egress gate on the exterior section of the Lokahi building affecting the exit door near bedroom #110. The gate had a lock requiring a key to access. In addition, a chain was wrapped around the gate preventing it from being opened. The gate provided a means of egress via a sidewalk to the public way.	K 211		

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K 211	Continued From page 2 Interview with the Maintenance Director at the time of each of the above observations indicated the facility implemented the locking mechanisms to keep wandering residents from eloping. The code requires under NFPA 101 (2012 edition) section 19.2.2.2.5 " ... required means of egress shall not be equipped with a latch or lock that requires the use of a key or tool from the inside."	K 211		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure the kitchen hood exhaust and extinguishing system was inspected every six months. This had the potential to affect 11 residents who resided in the Lokahi building. NFPA 96 (2011 edition) section 11.2.1. Findings include: Review of the fire safety records revealed documentation of inspections of the kitchen hood system by a certified company dated 02/20/20 and 03/22/21. Interview with the Maintenance Director at the time of the review on 03/25/21 at 4:00 PM verified the dates of the inspections as accurate and confirmed that no other inspections of the Kitchen hood system had been conducted between 02/20/20 and 03/22/21. The code requires under NFPA 96 (2011 edition) section 11.2.1 " ... maintenance of the fire extinguishing systems and listed exhaust hoods listed to extinguishing of fire and grease removal devices, hood exhaust plenums and exhaust ducts shall be made by properly trained, qualified and certified persons at least every six months."	K 324		
K 342 SS=E	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of	K 342		

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K 342	Continued From page 4 egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that alarm initiating devices (pull stations) were located within five feet of an exit doorway. This had the potential to affect the 33 residents who resided in the Laulima building. NFPA 101 (2012 edition) 19.3.4.1 to 9.6 to 9.6.1.1 to NFPA 72 (2010 edition) 17.14.6. Findings include: Observation of the pull station near bedroom #4 in the Laulima building on 03/25/21 at 9:05 AM revealed the pull station was located ten feet from the exit doorway. A second pull station was observed to be 11 feet from the exit doorway. The door had an exit sign above it and the floor plan on the wall directed the occupant to this door for exiting. Observation of the exit doorway near bedroom #15 in the Laulima building on 03/25/21 at 9:30 AM revealed the pull station serving this exit is 15 feet from this exit doorway. The door had an exit sign above it and the floor plan on the wall directed the occupant to this door for exiting. Observation of the pull station near the front exit door in the Laulima building on 03/25/21 at 2:30	K 342		

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K 342	Continued From page 5 PM revealed the pull station was eight feet from the exit doorway. The door had an exit sign above it and the floor plan on the wall directed the occupant to this door for exiting. Observation of the exit doorway near the nursing station leading to the central exit in the Laulima building on 03/25/21 at 2:35 PM revealed no pull station was available. The door had an exit sign above it and the floor plan on the wall directed the occupant to this door for exiting. Interview with the Maintenance Director at the time of each of the observations and measurements verified the distances noted above. The code requires in NFPA 101 (2012 edition) 19.3.4.1 to 9.6 to 9.6.1.1. to NFPA 72 (2010 edition) 17.14.6 "Manual fire alarm boxes shall be located within 60 inches (5 feet) of the exit doorway opening at each exit door on each floor."	K 342		
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 review of fire safety records and interview, the facility failed to ensure that smoke	K 345		

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K 345	Continued From page 6 detection sensitivity tests had been completed in accordance with NFPA 72 (2010 edition) sections 14.4.2.2. to 14.4.5.3.2 and failed to ensure that fire alarm tests had been conducted in accordance with NFPA 101 (2012 edition) section 19.7.1.4. This had the potential to affect all 42 residents who resided in the facility. Findings include: 1. Review of fire safety records revealed the facility lacked a smoke detection sensitivity report. All reports reviewed, including the most recent report dated 07/16/20, lacked a reference to a smoke detection sensitivity report. Interview with the Maintenance Director on 03/25/21 at 3:00 PM revealed the facility did not have a sensitivity report. The code requires at NFPA 72 table 14.4.2.2. that smoke detection sensitivity shall be completed every two years, and one year after a new detector is installed. In addition, the code requires at NFPA 72 (2010 edition) section 14.4.5.3.2 " ...sensitivity shall be checked every alternate year unless otherwise permitted." 2. Review of fire drill records revealed the facility lacked a test of the fire alarm system for the months of March 2020, May 2020, June 2020, August 2020, September 2020, November 2020, and December 2020. Interview with the Maintenance Director on 03/25/21 at 4:00 PM revealed the facility did not have evidence the fire alarm system was tested in the months noted above. The code requires at NFPA 101 section 19.7.1.4. " ...fire drills in health care occupancies shall	K 345		

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K 345	Continued From page 7 include the transmission of the fire alarm signal and simulation of emergency fire conditions."	K 345		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all areas of the building were provided with complete sprinkler coverage. This facility is listed as type V (111) wood frame combustible construction with wood frame bearing walls and roofing. This had the potential to affect all 42 residents who resided in the facility. NFPA 13 (2010 edition) section 8.1.1. Findings include:	K 351		

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K 351	Continued From page 8 1. Observations in the Laulima building on 03/25/21 from 9:05 AM to 10:10 AM of bedrooms #1, #2 #6, #7, #8, #9, #12, #13, #14, and #15 revealed two closets in each room measuring four feet wide by two feet deep without sprinkler coverage. Observation of a closet containing full and empty oxygen tanks on 03/25/21 at 9:00 AM revealed no sprinkler coverage for this room measuring four feet wide by three feet deep. Observation of the Information Technology (IT) closet containing computer equipment near bedroom #9 on 03/25/21 at 9:10 AM revealed the closet was lacking sprinkler coverage. The closet measured four feet wide by three feet deep. Observation of a closet in the maintenance room on 03/25/21 at 9:12 AM revealed the closet was lacking sprinkler coverage. The closet measured six feet wide by ten feet in length. Observation of a utility closet on 03/25/21 at 9:20 AM revealed the closet lacked sprinkler coverage. The closet measured three feet wide by ten feet long. Observation of a general supply closet on 03/25/21 at 9:25 AM revealed the closet lacked sprinkler coverage. The closet measured four feet wide by four feet long. Observation of the central supply closet containing medical supplies on 03/25/21 at 9:28 AM revealed the closet lacked sprinkler coverage. The closet measured six feet wide by nine feet in length.	K 351		

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K 351	Continued From page 9 Observation of the atrium on the wing containing bedrooms 12 through 15 revealed the area above the ceiling was lacking sprinkler coverage. The room is 30 feet in length and 20 feet wide. The area has a pitched roof that was once outside and remodeled with a new lower ceiling with a hole cut open in the lower ceiling revealing six skylights through the opening. The area is now completely inside. Observations of the attic above bedroom 13 on 03/25/21 at 11:00 AM revealed the entire attic is lacking sprinkler coverage. Interview with the Maintenance Director at the time of the above observations verified the lack of sprinkler coverage. The code requires under NFPA 13 (2010 edition) section 8.1.1. that sprinkler coverage shall be installed throughout premises. 2. Observations in the Lokahi building on 03/25/21 from 9:50 AM to 10:35 AM of bedrooms #103, #104, #105, #106, #107, #108, #109, and #110 revealed two closets in each room measuring four feet wide by two feet deep without sprinkler coverage. Observations of the electrical room with an entrance from the outside revealed it measured six feet wide by 10 feet long and did not have sprinkler coverage. During an interview at the time of the observations in the Lokahi building the Maintenance Director verified the area's observed did not have sprinkler coverage.	K 351		

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K 351	Continued From page 10 The code requires under NFPA 13 (2010 edition) section 8.1.1. that sprinkler coverage shall be installed throughout premises.	K 351		
K 352 SS=F	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the sprinkler system control valve had electronic supervision or a tamper switch. This had the potential to affect all 42 residents who resided in the facility. NFPA 13 (2010 edition) section 8.16.1.1.2. Findings include: Observation of the main sprinkler control valve on 03/25/21 at 10:55 AM revealed control valves above the ground in the front of the building near the road without electronic supervision or tamper switches. Neither valve had a tamper switch. Moreover, review of the alarm inspection report and sprinkler inspection report both dated 07/16/20 did not list the presence of a tamper switch for the main control valves of the sprinkler system.	K 352		

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K 352	Continued From page 11 Interview with the Maintenance Director at the time of the observation indicated the valves are main control valves and lack electronic supervision or tamper switches. Both valves are chained in the open position and locked with a pad lock requiring a key. The code requires under NPFA 13 (2010 edition) section 8.16.1.1.2. " ... valves on connection to water supplies and other valves in supply pipes to sprinklers shall be supervised by a local signaling service that will cause the sounding of an audible signal at a constantly attended point."	K 352		
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 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. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 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 review of fire safety documents and	K 353		

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K 353	Continued From page 12 interview, the facility failed to ensure that sprinkler inspections were conducted on an annual and quarterly basis. This had the potential to affect all 42 residents who reside in both buildings. NFPA 25 (2011) Table 5.1.1.2 Findings include: Review of the facility fire safety inspection documents revealed one quarterly inspection report dated 07/16/20 in the past twelve months. Absent was the annual inspection report and two additional quarterly sprinkler inspection reports. Interview with the Maintenance Director on 03/25/21 at 4:30 PM revealed that the reports provided were all that is available. The code requires under NFPA 25 (2011 edition) Table 5.1.1.2 that on a quarterly basis the waterflow device, alarm devices associated with the sprinkler system, and the valve supervisory system devices be checked. Annual inspections require bracing inspections, pipes and fittings inspections, and sprinkler head inspections. On an annual basis, hanger and bracing inspections, pipes and fittings inspections, sprinklers inspections and spare sprinklers inspections as well as information signs shall be inspected.	K 353		
K 364 SS=E	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing	K 364		

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K 364	Continued From page 13 patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that two corridor doors were without transfer grills. This had the potential to affect the 33 residents who resided in the Laulima building. NFPA 101 (2012 edition) section 19.3.6.5.2 and section 8.3. Findings include: Observation of the information technology (IT) closet corridor door in the Laulima building on 03/25/21 at 9:10 AM revealed the door had two transfer grills and one transfer grill in the wall above the door frame. The transfer grills in the door measured 16 inches wide by eight inches high. The transfer grill above the door measured 12 inches wide by eight inches high. The was nothing to prevent the passage of smoke and fire from the inside part of the door or from the room to the exit access corridor. Interview with the Maintenance Director at the time of the observation verified the condition of the door and the presence of the transfer grills.	K 364		

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K 364	Continued From page 14 The code at NFPA 101, (2012 edition) 19.3.6.5.2. to 8.3 requires that corridor doors resist the passage of smoke into the exit egress corridor and that " ... transfer grills in corridor doors are not used." Observation of a medication room storage door in the main corridor behind the nursing station in the Laulima building revealed two transfer grills measuring 12 inches wide by six inches high on 03/25/21 at 9:25 AM. One transfer grill was on the bottom of the door and the other was above the door in the wall. There was nothing to prevent the passage of smoke and fire from the inside part of the door or from the room to the dining room and exit access area. Interview with the Maintenance Director at the time of the observation verified the condition of the door and the presence of the transfer grills. The code at NFPA 101, (2012 edition) 19.3.6.5.2. to 8.3 requires " ... transfer grills in corridor door are not used."	K 364		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918		

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K 918	Continued From page 15 with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the emergency generator was tested under load monthly and failed to ensure the transfer switch room had emergency lighting. This had the potential to affect all 42 residents who resided in the facility. NFPA 110 (2010 edition) section 7.3.2 and NFPA 99 (2012 edition) section 6.4.4.1.1.4 (a)(b) Findings include: 1. Observation of the generating room on	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125061	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 16 03/25/21 at 10:45 AM revealed the transfer switch/electrical room lacked emergency lighting. Interview with the Maintenance Director at the time of the observation indicated there was no battery powered lighting in the room. The code requires under NFPA 110 (2010 edition) section 7.3.2 " ... the level 1 or level ll EPS (emergency power system) equipment location shall be provided with battery powered emergency lighting in accordance with 7.3.2 requiring the lighting to be supplied on the load side of the transfer switch." 2. Review of facility generator testing records revealed weekly generator inspections but no evidence of a monthly load test. Weekly inspections did not involve a test of the generator equipment. Interview with the Maintenance Director on 03/25/21 at 2:15 PM revealed he did not do monthly load tests in the past 12 months. The code requires under NFPA 99 (2012 edition) 6.4.4.1.1.4 (A) and (B) that (A) " ...generator sets shall be tested 12 times per year at intervals of not less than 20 days and not more than 40 days apart" and (B) "The scheduled test under load conditions shall include a complete and simulated cold start and appropriate automatic and manual transfer of all essential electrical and system loads."	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125061	A. BUILDING _____ B. WING _____	03/25/2021

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E 000	Initial Comments The facility was found 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

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.