Hawaii Dept. of Health, Office of Health Care Assurance

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 ______	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAUAI CARE CENTER	**9611 WAENA ROAD WAIMEA, HI 96796**

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4 000	Initial Comments A state re-licensure survey was conducted at the facility from 03/02/21 - 03/05/21. The facility's census was 43 residents at the time of entrance.	4 000		
4 156	11-94.1-40(d) Dietary services (d) The food service shall be directed by a dietary manager. If the food service is directed by a dietary manager who is not a dietitian, there shall be frequent and regularly scheduled consultation with, and in-service education by, a dietitian. Consultation and in-service education shall be appropriate to the needs of the dietary personnel and residents of the facility, and this shall be documented. In-service education specific to the needs of the dietary staff shall be provided at least on a semi-annual basis. This Statute 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.	4 156		

Office of Health Care Assurance

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

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 156	Continued From page 1 Findings Include: 1) On 03/02/21 at 12:21 PM, an interview and 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".	4 156		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject	4 159		

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4 159	Continued From page 2	4 159		

to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and

(2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage.

This Statute 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 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

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4 159	Continued From page 3	4 159		

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 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

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4 159	Continued From page 4	4 159		

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 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

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4 159	Continued From page 5 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.	4 159		
4 184	11-94.1-46(a) Pharmaceutical services (a) Each facility shall employ a licensed pharmacist, or shall have a written contractual arrangement with a licensed pharmacist, to provide consultation on methods and procedures for ordering, storing, administering, disposing, and recordkeeping of drugs and biologicals, and provisions for emergency service. This Statute 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. In addition, 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	4 184		

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4 184	Continued From page 6	4 184		

the duration of the prn order.

Findings Include:

1) 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 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

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4 184	Continued From page 7	4 184		

the following days: 02/09/21, 02/15/21, 02/18/21, and 02/25/21.

2) 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 HCI 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, 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.

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4 184	Continued From page 8 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 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.	4 184		

Hawaii Dept. of Health, Office of Health Care Assurance

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4 203	Continued From page 9	4 203		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute 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	4 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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4 203	Continued From page 10	4 203		

and leaving room; wear face mask; wear eye protection (face shield or goggles); gown and glove at door; when doing aerosolizing 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

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4 203	Continued From page 11	4 203		

Continued From page 11

acknowledged not following the procedures for using PPE.

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

Hawaii Dept. of Health, Office of Health Care Assurance

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4 203	Continued From page 12	4 203		

privacy). Staff members also store reusable PPE 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.

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 ______	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAUAI CARE CENTER	9611 WAENA ROAD WAIMEA, HI 96796

(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) COMPLETE DATE
4 203	Continued From page 13 Below the rack was a box of medium alcohol prep 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	4 203		

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4 203 | 4 203

Continued From page 14

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.

4 213 | 4 213

11-94.1-54(d) Sanitation

(d) Every facility shall maintain an effective pest control program so that the facility is free of pests and rodents.

This Statute 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.

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4 213	Continued From page 15	4 213		

Continued From page 15

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 LED Fly Lights are changed out once a month. MD unable to produce any product information for

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4 213	Continued From page 16	4 213		

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.