STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LILIHA HEALTHCARE CENTER	1814 LILIHA STREET HONOLULU, HI 96817

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Department of Health, Office of Health Care Assurance. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 02/17/21 through 02/19/21 Survey Census: 69 Sample Size: 18 Supplemental Residents: 0	F 000		
F 550 SS=D	. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		

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

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must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide access to persons and services inside and outside the facility. Resident (R)269 was not seen by a social worker from admission on 02/03/21 through the current day of 02/19/21 regarding discharge.

Findings include:

On 02/19/21 at 09:36 AM, with (Resident (R) 269) who stated that "no social worker has seen me." There is a place that I can go in Ewa Beach. It's a short term and I must call this realty. Surveyor asked R269 if she was sure that no social worker had talked with her? R269 stated no one except the surveyor has been talking with her.

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R269 is a 67-year-old female who was in the yellow zone, which is the area that is considered the 14-day quarantine unit for contact/droplet precautions, for new admissions. The yellow zone was zoned off from the remainder of the facility with plastic barrier walls. Surveyor interviewed R269 in the yellow zone.

Record review on 02/19/21 revealed that R269 had a history of metabolic encephalopathy on admission. Although her (Brief Interview for Mental status (BIMs) was 13, R269 was able to state her full name, the current date and describe her current situation regarding discharge back into the community during an interview.

Interview on 02/19/21 at 09:50 AM with (social worker (SW) who stated "no, I have not talked with her." I have been trying to talk to her son whom I asked about her assets and financial status, but I am not sure he is reliable. Because she is not reliable mentally, I am not sure that I can rely on talking with her. Surveyor stated to SW that the resident seemed to be cognizant enough and was sure she had not seen a SW. SW stated, "I was told that once I go in the back, I cannot come back into the facility." (Assistant director of nursing (ADON) who was sitting at the nurse's station during interview with SW emphasized that "we don't have an outbreak" and you can come back in, but you must don and doff. Surveyor inquired with ADON who is updating and teaching their ancillary staff. ADON stated that their educator left last Friday.

Review on 02/19/21 Social Services progress notes revealed an in-person meeting with R269 on 02/19/2021 at 10:47 AM. Record also

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F 550	Continued From page 3 confirmed that resident was admitted on 02/03/2021 and had not been seen by social services until the sixteenth day in the facility.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure that an interdisciplinary team had determined that it was appropriate for a resident to self-administer medications for one of 18 sampled residents (Resident (R) 14). On 02/17/21, R14 was provided medications to self-administer without an assessment or physician's order. Findings include: Review of the facility's policy titled, "Administration of Medications," reviewed 02/02/19, revealed " ...General Rules for Medication Administration: ...4. The Interdisciplinary Team has determined in the interest of all residents' safety, that no self-administration of medication will be allowed, except for the following and only after visual inspection by the Director of Nursing. 1. Vitamins. 2. Herbs. 3. Eye Drops. 4. Non-steroid topical creams/ointments. 5. Inhalers. Interdisciplinary Team must justify that resident [sic] is capable of self-administering his/her medications and an order from the Attending Physician must be	F 554		

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obtained prior to allowing self-administration of these medications and for allowing them to be kept at the resident's bedside ...7. Pre-poured medication shall not be left at the resident's bedside ...unless so ordered by the MD [Medical Doctor] for self-administration ...14. Licensed nurse will remain with the resident and face him/her until the medication is swallowed."

Review of R14's undated "Resident Face Sheet," located in the resident's electronic medical record (EMR) under the face sheet tab, revealed the resident was a long-term resident with diagnoses which included Parkinson's disease, major depressive disorder, essential hypertension, dementia, hyperlipidemia, gastro-esophageal reflux disease, and osteoporosis.

Review of R14's physician "Orders," dated from 02/01/21-02/28/21 revealed the resident was ordered by her physician to receive the following medications: Zoloft (medication used to treat depression) oral tablet 150 mg (milligram) every AM (before noon) for recurrent depression; cetirizine (an antihistamine) HCL oral tablet 10 mg twice daily for itching; Losartan Potassium (medication used to treat hypertension) oral tablet 100 mg daily for hypertension; raloxifene (used to treat osteoporosis) HCL oral tablet 60 mg daily; Norvasc (used to treat blood pressure) oral tablet 10 mg daily, Rasagiline Mesylate (used to treat Parkinson's Disease) oral tablet 1 mg daily; Vascepa (used to treat cholesterol) oral capsule 2 mg twice a day; and Potassium Chloride ER (supplement) oral capsule 10 mg daily.

Observation on 02/17/21 at 11:20 AM revealed R14 was sitting on the edge of her bed conversing with her roommate. Continued

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F 554	Continued From page 5 observation revealed a small medication cup containing multiple medications, was on top of the resident's bedside table. Interview on 02/17/21 at 11:27 AM with Registered Nurse (RN) 4 revealed that when she brought R14 the medications earlier that morning, the resident told her she would take them in a few minutes. RN4 stated she usually goes back and checks to make sure the resident takes them; however, she did not this morning. RN4 also stated R14 did not have a physician's order to self-administer medications. The RN confirmed the following medications were at the resident's bedside: Zoloft tablet, cetirizine tablet, Losartan Potassium tablet, raloxifene tablet, Norvasc tablet, Rasagiline Mesylate tablet, Vascepa capsule, and Potassium Chloride capsule. Interview on 02/19/21 at 4:14 PM with the Administrator revealed it was his expectation the RN would have ensured the medications were administered to the resident and the resident did not self-administer medications unless ordered and assessed to do so. Interview on 02/19/21 at 4:55 PM with the Director of Nursing (DON) revealed it was his expectation that, unless a resident had an order from a physician to self-administer, medications should not be left at a resident's bedside.	F 554		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		

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supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, the facility failed to provide a homelike

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environment and to maximize the resident's independence in the COVID-19 quarantine isolation unit.

Findings include:

Observation and interview on 02/17/21 at 11:59 AM with Resident (R)269 were done. R269 is a 67-year-old female who was in the yellow zone, which is the area that is considered the 14-day quarantine unit for contact/droplet precautions, for new admissions. The yellow zone was zoned off from the remainder of the facility with plastic barrier walls. Surveyor interviewed R269 in the yellow zone. Resident was able to quote the date she had been admitted. However, R269 had to look approximately 20' to her neighbor's area where a calendar was on the closet door. Resident 269 stated that she did not have a calendar on her closet door and had to squint to see the calendar across the room. It was also noted that there were no pictures or homelike décor in the room at the time.
Observation on 02/19/21 at 0945 AM in R269's room revealed only one calendar in the room to be shared by two residents.

Review of the facility's admission packet on 02/17/21 given to the resident did state that the facility would provide a homelike environment.

Interview on 02/19/21 at 09:55 AM with (Licensed practical nurse (LPN)1) who was asked what the practice is to provide a homelike environment and if a calendar for R269 could be provided. LPN1 agreed that it was not homelike to have to share one calendar to a room and stated she could fix it.

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F 607	Continued From page 8	F 607		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy, and review of the facility's investigation report, the facility failed to develop abuse policies that included current required time frames for reporting abuse. In addition, the facility failed to assure that its policies provided procedures regarding conducting thorough investigations when abuse was alleged. The failure to have current, comprehensive abuse policies affected one of 18 sampled residents (Resident (R) 12) whose allegation of abuse was not reported to the State Agency (SA), and was not thoroughly investigated. Findings include: 1. Review of an "Investigation Report," dated 12/08/20 revealed R12 reported an allegation of sexual and verbal abuse. (Please refer to F609.) Review of the "Investigative Report" revealed no evidence that the facility reported this allegation to the SA.	F 607		

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Review of the facility's policy titled, "Policy on Abuse, Neglect, and Exploitation," reviewed 11/2019, revealed: " Reporting: 2. In the event that any individuals suspects an abuse or incidents of abuse, he or she must report the incident to the nurse supervisor or charge nurse who will then report the incident to the Director of Nursing, or the Director of Social Service, or the Administrator. 3. If the incident occurred or discovered after hours or during the weekend, the above personnel must be called at home and informed of such incident not later than 2 hours after forming the suspicion of abuse. 4. Any suspected abuse that results to serious bodily injury must be reported to OHCA [Office of Health Care Assurance] and Administrator (or designated representative) within 2 hours of the incident ...6. The Director of Nursing and the Director of Social Services will do an investigation and file a follow-up report. When there is an alleged or suspected case of mistreatment, neglect, injuries of unknow origin, or abuse, the Director of Social Services will notify the appropriate agencies immediately or within 24 hours."

Review of the facility policy revealed that it did not meet the current requirements of 42 CFR 483.12 which requires that all allegations of abuse, not just ones that result in serious bodily injury, be reported to the SA (OHCA) within two hours.

2. Review of the "Investigation Report," dated 12/08/20 regarding R12's allegation of sexual and verbal abuse revealed a thorough investigation was not conducted. (Please refer to F610.) There was no evidence that the facility

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F 607	Continued From page 10 interviewed any residents besides the alleged victim while investigating R12's allegation of abuse. Review of the facility's policy titled, "Policy on Abuse, Neglect, and Exploitation," reviewed 11/2019, revealed that it did not include procedures to assure that a thorough investigation was conducted whenever abuse was alleged. The policy failed to address the need for observations, as well as the need to interview other staff and residents who might have been a witness to the alleged abuse. The policy did not address the need to interview other residents who had received care from the same alleged perpetrator to help identify possible patterns of behavior. Interview on 02/19/21 at 3:56 PM with the Social Work Director (SWD) revealed that the Director of Nursing (DON) and Administrator served as the facility's Abuse Coordinators. Interview on 02/19/21 at 4:06 PM with the Administrator confirmed that R12's allegation of abuse had not been reported to the SA. The Administrator was unaware that the facility's policies did not meet current requirements, as he stated he did not know the regulation that abuse had to be reported to the SA within two hours.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		

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§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's policy, the facility failed to ensure an allegation of abuse was reported to the State Agency (SA) within two hours for one of 18 sampled residents (Resident (R) 12). On 12/08/20, R12 reported an allegation of sexual and verbal abuse to the facility; however, the facility did not report the allegation to the SA. In addition, the facility failed to report the findings of its investigation to the SA within five working days as required by regulation.

Findings include:

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Review of the facility's policy titled, "Policy on Abuse, Neglect, and Exploitation," reviewed 11/2019, revealed " ...2. In the event that any individual suspects an abuse or incidents of abuse, he or she must report the incident to the nurse supervisor or charge nurse who will then report the incident to the Director of Nursing, or the Director of Social Service, or the Administrator. 3. If the incident occurred or discovered after hours or during the weekend, the above personnel must be called at home and informed of such incident not later than 2 hours after forming the suspicion of abuse. 4. Any suspected abuse that results to serious bodily injury must be reported to OHCA [Office of Health Care Assurance] and Administrator (or designated representative) within 2 hours of the incident ...When there is an alleged or suspected case of mistreatment, neglect, injuries of unknow origin, or abuse, the Director of Social Services will notify the appropriate agencies immediately or within 24 hours ..." Continued review of the facility's policy revealed the facility's policy did not require that all allegations of abuse must be reported to the SA within two hours. (Please refer to F607.)

Review of the facility's abuse "Investigation Report," dated 12/08/20 revealed an allegation that R12 was abused. Per this "Investigation Report, the date of the incident was 12/08/20. The "Investigation Report" documented that "Resident [R12's initials] reported to the LPN [Licensed Practical Nurse] ...LPN [name] called the social worker [Social Work Director (SWD)] to report the incident. Social Worker made a virtual interview with the resident and the statement of the resident are as follows: CNA [Certified

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F 609	Continued From page 13 Nursing Assistant] Grab and hold my crotch. Yells at met-get in the shower [;] get there to the bed. That during shower rubbing my private. CNA also used his arm around my back. Rubbed hand on crotch while showering. Berating me." Further review of the 12/08/20 "Investigation Report" revealed no evidence that the initial allegation of sexual and verbal abuse was ever reported to the SA. In addition, there was no evidence that the facility reported the findings of their investigation to the SA within five days. Interview on 02/19/21 at 3:56 PM with the Social Work Director (SWD) revealed she would not be the person who reported abuse to the SA. The SWD identified the Director of Nursing (DON) and Administrator as the Abuse Coordinators for the facility. Interview on 02/19/21 at 4:06 PM with the Administrator revealed he was not aware that all allegations of abuse had to be reported to the SA within two hours. Per the Administrator, the facility had waited for the former DON to complete the investigation prior to reporting the allegation to the SA. He continued that, once the former DON determined that abuse was not substantiated, neither the initial allegation of sexual and verbal abuse, nor the required five-day report with the investigation's conclusion was ever reported to the SA.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		

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§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's policy, the facility failed to ensure an allegation of abuse was thoroughly investigated for one of 18 sampled residents (Resident (R) 12). On 12/08/20, R12 reported an allegation of sexual and verbal abuse to the facility; however, the facility did not complete a thorough investigation.

Findings include:

Review of the facility's policy titled, "Policy on Abuse, Neglect, and Exploitation," reviewed 11/2019, the policy did not entail a procedure that ensured all allegation of abuse were thoroughly investigated which included interviewing others (staff and residents) who might be witnesses, as well as other residents who may have received care from the alleged perpetrator. (Please refer to F607.)

Review of R12's undated "Resident Face Sheet,"

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revealed the resident was admitted to the facility on 12/02/20 with diagnoses which included unspecified viral hepatitis C, bipolar disorder, and anxiety disorder. Per R12's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 12/11/20, the facility assessed the resident to have a "Brief Interview for Mental Status (BIMS)" score of nine out of 15, which indicated the resident was moderately cognitively impaired.

Review of the facility's "Investigation Report," dated 12/08/20 revealed that six days after admission, on 12/08/20, R12 reported an allegation of sexual and verbal abuse. Review of this "Investigation Report" revealed that the former Director of Nursing (DON) was responsible for the investigation. The "Investigation Report," stated that R12 alleged that a "CNA [Certified Nursing Assistant] Grab and hold my crotch. Yells at met-get in the shower [;] get there to the bed. That during shower rubbing my private. CNA also used his arm around my back. Rubbed hand on crotch while showering. Berating me."

Per the 12/08/20 "Investigation Report," the former DON noted the "Summary of the Incident: Resident is alert and level of orientation is 1-2 ...she has episodes of visual hallucination like seeing somebody like her Mom, nephew, or children in the room. She's easily distracted. In the ADL [activities of daily living] record her level of participation is supervision and setup only. So the claim of being showered and provided with perineal care is impossible because she can do it without help ...After using the bathroom CNA hold her gown at the back to cover her back ...The DON concluded this claim as unsubstantiated as

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F 610	Continued From page 16 verified by the LN [licensed nurse] and CAN [sic] statement regarding her personality." Further review of the 12/08/20 "Investigation Report" revealed no evidence that the facility attempted to identify if there were any other potential witnesses (either staff or other residents) and interview them prior to making a determination that the resident's allegation was unsubstantiated. There was no evidence that the facility identified other residents for whom the alleged perpetrator had provided care, and then interviewed them as part of a thorough investigation. Interview on 02/19/21 at 3:56 PM with the Social Work Director (SWD) revealed she interviewed R12 but did not interview any other residents. Interview on 02/19/21 at 4:06 PM with the Administrator revealed the former DON informed him of R12's mental illness, stated there was no evidence of harm, the resident felt safe, and the investigation determined it was more a "rough care performance" rather than abuse. Further interview with the Administrator revealed it was normal protocol for the facility to interview other residents if the resident who made the allegation did not have a history of false allegations. Per the Administrator, he was unaware that this had not been done as a part of this investigation.	F 610		
F 623 SS=F	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623		

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representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section

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F 623	Continued From page 18 must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews, it was determined the facility failed to ensure the Ombudsman was notified of a transfer from the facility to an acute care setting for one of 18 sampled residents (Resident (R) 64). The facility failed to have policies and procedures in place to assure that that the Ombudsman received a copy of all written transfer notices. The systemic failure to notify the Ombudsman had the potential to affect all 69 residents of the facility who could require transfer to another health care facility.

Findings include:

Review of R64's undated "Resident Face Sheet," located in the resident's Electronic Medical Record (EMR) under the face sheet tab, revealed the resident was admitted to the facility on 12/31/20.

Review of R64's "Nursing Progress Notes," dated 01/24/21, revealed the resident was transferred to the hospital for a non-COVID-19 related concern. Per the "Nursing Progress Notes," the facility, " ...Obtained order to transfer resident to acute facility via 911 ambulance ... paramedics came in

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F 623	Continued From page 20 at around 9:15 Pm [sic] ..." Review of R64's undated "Resident Face Sheet" revealed the resident was readmitted to the facility on 01/29/21 with diagnoses which included sepsis. Review of R64's EMR revealed no documented evidence the Ombudsman was notified of the resident's transfer to the hospital on 01/24/21. Interview on 02/19/21 at 2:56 PM with the Social Work Director (SWD) revealed the facility does not notify the Ombudsman when residents transfer to the hospital. Further interview with the SWD revealed that the facility did not have a policy that addressed this requirement. Interview on 02/19/21 at 2:57 PM with the Administrator confirmed the facility does not notify the Ombudsman in writing of resident transfers to the hospital. The Administrator stated he was not aware the facility needed to notify the Ombudsman of resident transfers to the hospital.	F 623		
F 625 SS=F	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state	F 625		

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plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interviews, record reviews, and review of the facility's admission paperwork, it was determined the facility failed to ensure all residents were provided a written notice which specified the duration of the bed-hold policy at the time of transfer to the hospital for one (Resident (R) 64) of 18 sampled residents. On 01/24/21, R64 was transferred to the hospital after a change of condition; however, she was not given the written notice that addressed holding the resident's bed during her absence. The systemic failure to offer and provide notice of the facility's practices regarding bed holds had the potential to affect any residents who could require transfer to another health care facility.

Findings include:

Review of the facility's admission packet titled "Resident Handbook," revised 08/2019, revealed " ...Resident & Guest Information ...Bed Hold.

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Once discharged from [facility name], beds are not held for residents, unless requested by the resident or resident representative. Request to hold a bed must be made within 24 hours of discharge at the per diem rate. Otherwise, a discharged resident can be re-admitted if a bed becomes available and if we [facility] are able to meet the resident's medical needs. For Medicaid eligible residents, a bed will be held for 3 days, should a resident be transferred for hospitalization or therapeutic leave and should the absence exceed the 33-day requirement, the resident may return to the facility in the first available bed ..."

Review of R64's undated "Resident Face Sheet," located in the resident's Electronic Medical Record (EMR) under the face sheet tab, revealed the resident was admitted to the facility on 12/31/20 and readmitted on 01/29/21 with diagnoses which included sepsis.

Review of R64's "Nursing Progress Notes," dated 01/24/21 revealed " ...Obtained order to transfer resident to acute facility via 911 ambulance ...paramedics came in at around 9:15 Pm [sic] ..."

Review of R64's EMR revealed no documented evidence a bed hold notice was given to the resident upon her transfer to the hospital on 01/24/21.

Interview on 02/19/21 at 1:33 PM with the Social Work Director (SWD) revealed the facility did not have an official bed hold policy. The SWD stated the facility's admission paperwork stated the facility did not offer bed holds.

Interview on 02/19/21 at 4:17 PM with the

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F 625	Continued From page 23 Administrator revealed it was his expectation a bed hold would have been given upon R64's transfer to the hospital. Interview on 02/19/21 at 4:51 PM with the Director of Nursing (DON) revealed he was not aware that bed holds were to be offered to residents.	F 625		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, review of dishwasher temperature logs, and dishwashing machine specifications, the facility failed to assure that the dishwashing machine used sufficiently hot water temperatures in accordance with the manufacturer's instructions. The failure	F 812		

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to correctly clean and sanitize dishware had the potential to affect 64 of 69 residents who consumed an oral diet that was prepared in and/or served on this dishware.

Findings include:

Review of the dishwasher specifications for the facility's low temperature, sanitizing dishwasher revealed the temperature should be maintained at 120 degrees Fahrenheit when coupled with the use of sanitizer. Review of the facility dishwasher temperature log on 02/18/21 at 8:55 AM revealed each day for the month of February 2021 indicated that the dishwasher temperature was 120 degrees Fahrenheit (F).

Observations on 02/18/21 at 8:55 AM revealed the dishwashing gauge recorded hot water temperatures of 88 degrees, F, 90 degrees F, 90 degrees F, and 98 degrees F while running to clean successive loads of breakfast dishes. These dishes were processed and stacked for re-use as clean/sanitized.

Interview with the Dietary Manager (DM) at 9:00 AM revealed the gauge on the dishwashing machine was working. She continued to process additional loads, with the gauge next showing water temperatures of 106 degrees F, 108 degrees F, and 110 degrees F. The DM stated, "We will call the maintenance man to increase the hot water tank temperature." Hot water in the dishwasher was recorded at 118 degrees F at 9:45 AM.

Interview with the Maintenance Director on 02/19/21 at 11:00 AM revealed that the temperature for the hot water tank had previously

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F 812	Continued From page 25 been set at 110 degrees F and was turned up to 130 degrees F on 02/18/20 after surveyor intervention.	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 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	F 880		

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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.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, review of screening and personnel records, and facility policies, the facility failed to ensure that two of 32 staff were screened for COVID-19 prior to beginning work on first shift on 02/19/21. The failure to screen all staff had the potential to affect

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F 880	Continued From page 27	F 880		

all 69 residents.

Findings include:

1. Observation on 02/19/21 at 7:00 AM revealed Receptionist 1, who was responsible for screening staff and ensuring all processes were followed, did not screen herself. At this time, Receptionist 1 was observed walking into the building through the main entrance, assisting staff with screening and going behind the desk to take staff temperatures. However, the receptionist, herself, was not screened prior to entering into the building.

Review of the facility screening records and time clock records confirmed that as of 2:30 PM on 02/19/21, Receptionist 1, who came into contact with all staff that entered the building for the 7:00 AM to 3:00 PM shift, had still not been screened for the day.

During an interview with Receptionist 1 on 02/19/21 at 2:35 PM, she stated "I forgot to sign in."

2. Further review of the screening records on 02/19/21 at 2:30 PM revealed that Dietary Aide (DA) 2 was not screened at the start of her shift. The COVID-19 screening process did not record her as entering the facility. However, review of time clock records revealed that DA 2 worked her entire shift.

Interview with DA 2 at 2:40 PM on 02/19/21 revealed that she did not remember if she signed in or not. When informed there was no record of her signing in or being screened, she stated "I

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F 880	Continued From page 28 don't know." Review of the facility's "COVID-19 Policies and Procedures" dated 09/01/20, revealed all staff entering on their shift will be asked to use alcohol-based hand rub, sign in and check their body temperature prior to starting their shift.	F 880		

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E 000	Initial Comments A recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Department of Health, Office of Health Care Assurance on 02/17/21 through 02/19/21. The facility was found to be in compliance with 42 CFR 483.73.	E 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Management Solutions, LLC on behalf of the Department of Health, Office of Health Care Assurance from 02/19/21 to 02/22/21. 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=E	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, review of the floor plan, and interview with the Administrator, the facility failed to ensure that exit locations are in accordance with NFPA 101 (2012 edition) Chapter 7. This has the potential to affect the 26 residents living on the first floor. Findings include: Observations of the front exit doors on 02/19/21 at 7:00 AM revealed the double glass doors are locked at all times with a deadbolt lock. Review of the facility floor plan posted on the wall show the door are identified as a means of egress.	K 211		

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K 211	Continued From page 1 During an interview at the time of the observation, the Administrator stated that the lock is used to prevent the homeless and other intruders from entering the building. The code requires under NFPA 101 (2012 edition) section 7.2.1.5.3. that " ... locks if used, shall not require the use of a key, a tool or special knowledge or effort from the operation of the egress side of the door."	K 211		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is	K 222		

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K 222	Continued From page 2 protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview with the Administrator, the facility failed to ensure that special locking arrangements used met the code in accordance with NFPA 101 (2012 edition)	K 222		

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K 222	Continued From page 3 section 7.2.1.6.1. and 7.1.10.2.1. This deficient practice had the potential to affect all 69 residents. Findings include: Observations of a stairway exit door near bedroom #111 on 02/19/21 at 7:00 AM revealed a special locking arrangement that was only activated by the wander guard system. Two residents on the second floor have a wander guard system to control dangerous wandering behaviors. The doors had a large red stop sign taped to the center and an illuminated exit sign was above the door. The floor plan on the wall in the unit directed occupants to this stairway door. The door was put into delay with a wander guard eventually locking the door and releasing in 15 seconds. The door lacked a sign to "push until alarm sounds, door will open in 15 seconds." Observations of the exit door on the second floor near the nursing station at 7:20 AM on 02/19/21 revealed a special locking arrangement on both doors. Both doors had large red stop signs and an illuminated exit sign above the door. The floor plan on the wall in the unit directed occupants to the stairway door noted above. The special delayed locking arrangement is only activated by the wander guard system. Two residents on the second use the wander guard system to control dangerous wandering behaviors. The doors were put into delay with a wander guard eventually locking the doors and releasing in 15 seconds. The door lacked a sign to "push until alarm sounds, door will open in 15 seconds." Observations of a stairway exit door near bedroom #211 on 02/19/21 at 7:50 AM revealed a	K 222		

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K 222	Continued From page 4 special locking arrangement that was only activated by the wander guard system. One resident on the first floor has a wander guard system to control dangerous wandering behaviors. The doors had a large red stop sign taped to the center. An illuminating exit sign was above the door. The floor plan on the wall in the unit directed occupants to the stairway door noted above. The door was put into delay with a wander guard eventually locking the door and releasing in 15 seconds. The door lacked a sign to "push until alarm sounds, door will open in 15 seconds." Observations of the exit doors on the second floor near the nursing station at 7:55 AM on 02/19/21 revealed a special locking arrangement on both doors and both doors had large red stop signs. The special delayed locking arrangement is only activated by the wander guard system. One resident on the second uses the wander guard system to control dangerous wandering behaviors. An illuminating exit sign was above the door. The floor plan on the wall in the unit directed occupants to the stairway door noted above. The doors were put into delay with a wander guard eventually locking the doors and releasing in 15 seconds. The door lacked a sign to "push until alarm sounds, door will open in 15 seconds." Interview with the Administrator at the time of each observation confirmed the door does not have a proper signage. The code does not permit stop signs on doors under NFPA 101 (2012 edition) section 7.1.10.2.1. which states that "no furnishings, decorations or other objects shall obstruct exits or their access thereto, egress therefrom or visibility	K 222		

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K 222	Continued From page 5 thereof." The code requires under NFPA 101 2012 edition section 7.2.1.6.1 the delayed egress locking systems can be approved under certain conditions. Those conditions include the following; if the door leaves unlock in exit direction, if the door unlocks with the activation of an approved sprinkler system, heat detectors or two smoke detectors, if the door releases with the loss of power and if the door releases after 15 seconds of pressure not less than 15 pounds.	K 222		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview with the Administrator, the facility failed to ensure that one exit discharge had a hard surface to the public way that was slip resistant and free of obstructions. This deficient practice had the potential to affect all 69 residents who resided in the facility CMS letter 05-38 dated 07/14/05 and NFPA 101 section 7.3.4 (2), 3.3.83, and 7.1.10.2.1. Findings include: Observation of the exit stairway near bedroom	K 271		

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K 271	Continued From page 6 #111 on 02/19/21 at 7:35 AM revealed the following: 1. The exit discharge was connected to a ramp and then to a sidewalk that was covered with mud and debris which made the sidewalk slippery and not passable. Interview with the facility Administrator at the time of the observation verified the pathway was too slippery due to the mud and debris to safely maneuver. The code requires under NFPA 101 section 7.1.6.4. " ... walking surfaces shall be slip resistant under foreseeable conditions. The walking surface of each element of the means of egress shall be uniformly slip resistant along the natural path of travel." 2. The path of travel to the public way stopped 30 feet short of the sidewalk gate. Interview with the Administrator at the time of the observation verified the sidewalk did not extend to the public way for 30 feet. The code requires under NFPA 101 (2012 edition) section 3.3.83 " ...exit discharge is defined as that portion of a means of egress between the termination of an exit and the public way." 3. The path of travel to the public way had three large plastic chairs next to one another. The position of the chairs allowed for slightly more than one foot of passage down the ramp for approximately eight feet of the ramp. Interview with the Administrator at the time of the	K 271		

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K 271	Continued From page 7 observation verified the chairs obstructed the passage down the ramp. The code requires under NFPA 101 (2012 edition) section 7.1.10.2.1. that " ...no furnishings or decorations or other objects shall obstruct exit or their access thereto, egress there from or visibility thereof."	K 271		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)	K 321		

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K 321	Continued From page 8 g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview with the Administrator, the facility failed to ensure that one hazardous area was protected by a self-closing door. This deficient practice had the potential to affect five staff who work in the area. NFPA 101 (2012 edition) section 19.3.2.1.3. Findings include: Observation on 02/19/21 at 7:55 AM of the corridor which housed the Human Resources and Medical Records office on the second floor located near the elevator revealed the room contained large amounts of paper storage including all of the facility Human Resources files and all medical records. The corridor door was not self-closing and remained ajar when opened. Interview with the Administrator at the time of the observation verified the door was not self closing. The code requires under NFPA 101 (2012 edition) section 19.3.2.1.3 "The doors shall be self closing."	K 321		
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	K 345		

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K 345	Continued From page 9 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 alarm reports and interview with the Administrator, the facility failed to have evidence to confirm the smoke detectors were inspected and tested for smoke detection sensitivity. This deficient practice had the potential to affect all 69 residents who reside in the facility. NFPA 72 (2010 edition) sections 14.4.5.3.2 and table 14.4.2.2. Findings include: Review of alarm inspection reports for the past 24 months revealed the reports did not address smoke detection sensitivity testing having been performed. Interview with the Administrator on 02/22/21 at 10:40 AM revealed the system is a smart system that continuously monitors; however, no written report is available. The Administrator stated the facility has hard wired smoke detectors in all bedrooms and all corridors every 30 feet and at smoke doors. The code requires at NFPA 72 (2010 edition) section 14.4.5.3.2 that smoke " ... sensitivity shall be checked every alternate year unless otherwise permitted." The code also requires annual testing of the smoke detection system and bi-annual visual inspections of the smoke detection system according to NFPA 72 (2010 edition) table 14.4.2.2.	K 345		
K 351 SS=F	Sprinkler System - Installation	K 351		

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K 351	Continued From page 10 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 with the Administrator, the facility failed to ensure sprinklers were installed throughout the premises and the facility had complete sprinkler coverage. This deficient practice had the potential to affect all 69 residents who resided in the facility. NFPA 13 (2010 edition) section 8.1.1. Findings include: 1. Observation on 02/19/21 at 8:00 AM revealed a walk-in refrigerator in the basement measuring 10 feet long by six feet wide without sprinkler coverage. The cooler contained an electric compressor for cooling. Interview with the Administrator at the time of the	K 351		

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	125041	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/22/2021**

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K 351	Continued From page 11 observation verified the walk-in refrigerator lacked sprinkler coverage. 2. Observation on 02/19/21 at 8:00 AM revealed a walk-in freezer in the basement measuring six feet long by four feet wide without sprinkler coverage. The freezer contained an electric compressor for cooling. Interview with the Administrator at the time of the observation verified the walk-in freezer lacked sprinkler coverage. 3. Observation on 02/19/21 at 7:30 AM and 8:10 AM revealed two supply closets near the rubbish chute on the first and second floors measuring six feet long by three feet wide lacking sprinkler coverage. The closet contained paper supplies and housekeeping supplies. Interview with the administrator at the time of the observation verified the lack of sprinkler coverage in each supply room. 4. Observation on 02/19/21 at 7:50AM revealed the physical therapy room closet on the first floor measuring four feet wide by four feet long to be lacking sprinkler coverage. The room contained paper and therapy supplies. Interview with the Administrator at the time of the observation verified the closet lacked sprinkler coverage. 5. Observation on 02/19/21 at 7:50 AM revealed a nursing supply closet near the nurse station on the first floor lacked sprinkler coverage. The room contained nursing supplies.	K 351		

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K 351	Continued From page 12 Interview with the Administrator at the time of the observation verified the closet lacked sprinkler coverage. 6. Observation on 02/19/21 at 8:05 AM revealed the laundry room in the lower level had an upright sprinkler head that did not cover the room. Below the sprinkler head was a large florescent light measuring two feet wide by four feet in length and a large duct measuring four feet wide extending over the entire length of the room. Sprinkler activation would be disrupted by these two objects thus effecting coverage in the laundry room. The code requires under NFPA 13 (2010 edition) section 8.1.1. that sprinkler coverage shall be installed throughout the premises. The code requires under NFPA 13 (2010 edition) section 8.1.1.3 that "sprinklers shall be positioned and located so as to provide satisfactory performance with respect to activation time and distribution."	K 351		
K 364 SS=D	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 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	K 364		

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K 364	Continued From page 13 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 with the Administrator, the facility failed to ensure that transfer grills are not used in corridor doors. This deficient practice had the potential to affect five staff working in the area. NFPA 101 (2012 edition) section 19.3.6.4.1. Findings include: 1. Observation of a closet measuring four feet by four feet in the first-floor corridor near the business office on 02/19/21 at 10:00 AM revealed the entire door was a transfer grill. The room was used to store paper and documents. The transfer grill will allow for the passage of smoke and fire into the exit access corridor. Interview with the Administrator at the time of the observation verified the door would allow the passage of smoke and fire. The code requires under NFPA 101 (2012 edition) section 19.3.6.4.1. that " ... transfer grills, regardless of whether they are protected by fusible link-operated dampers, shall not be used in corridor walls or doors. " 2. Observation of the first-floor conference room on 02/19/21 at 10:00 AM revealed the dutch door in the corridor had an opening of ½ inch gap in	K 364		

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K 364	Continued From page 14 the center of the door. Each leaf can be opened. The gap was along the width of the entire door. Interview with the Administrator at the time of the observation verified the condition of the dutch door. The code requires under NFPA 101 (2012 edition) section 8.3.4.4. " ... where a 20-minute fire protection rated door is required, it shall be solid wood core."	K 364		
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82	K 541		

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K 541	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation and interview with the Administrator, the facility failed to ensure that rubbish/trash and soiled linen chutes resist the passage of smoke and fire. This deficient practice had the potential to affect all 69 residents who resided in the facility. NFPA 101 (2012 edition) section 8.3.4.1. Findings include: 1. Observation on 02/19/21 at 7:45 AM revealed the trash chute and linen chute each had doors in the storage room on the first floor that had holes of varying sizes due to screw holes after locks were removed. In addition, the trash chute door was observed ajar about one inch. 2. Observation on 02/19/21 at 8:00 AM revealed the trash chute and linen chute each had doors in the storage room on the second floor that had holes of varying sizes from locks being removed. In addition, the linen chute door was observed ajar. 3. Observation of the linen chute in the laundry room on the lower level on 02/19/21 at 8:05 AM revealed that when the door was released from its latching device, it allowed linen to pass and did not automatically close leaving the door wide open or ajar about two feet wide. The Administrator was present at each of the above observations. During interview at the time of each observation, the Administrator verified the condition of the trash chute doors and the linen chute doors.	K 541		

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K 541	Continued From page 16 The code requires under NFPA 101 (2012 edition) section 8.3.4.1. that " ... every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to another."	K 541		
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview with the Administrator, and review of contractor generator reports, the facility failed to ensure the remote annunciator was functioning properly. This deficient practice had the potential to affect all 69 residents who resided in the facility. NFPA 99 (2012 edition) section 6.4.1.1.1.6.2 and 6.4.1.1.17. Findings include: Observation of the remote annunciator panel on 02/19/21 at 9:15 AM on the first floor behind the nursing station revealed the panel was not illuminating any visible signal. The lack of a green light display revealed the facility cannot determine if the system Type II EPSS is operational.	K 916		

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K 916	Continued From page 17 Interview with the Administrator at the time of the observation indicated the device " ... has always been this way" and "we've never had a light on the panel." Review of the generator contractor report dated 09/04/20 revealed no reference to the remote annunciator panel. The code requires under NFPA 99 (2012 edition) section 6.4.1.1.17. that " ... a remote annunciator that is storage battery powered shall be provided to operate outside of the generating room."	K 916		
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 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	K 918		

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K 918	Continued From page 18 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 and interview with the Administrator, the facility failed to ensure that the natural gas generator was installed, tested, and equipped with emergency lighting in the generator room. This has the potential to affect all 69 residents who resided in the facility NFPA 99 (2012 edition) section 3.3.5, NFPA 110 (2010 edition) section 7-13.4.3 and NFPA 110 (2010 edition) section 7.3.1. and 7.2.1.2. Findings include: 1. Observation on 02/19/21 at 9:45 AM revealed the 15 KW generator is powered by the local utility through natural gas service. The natural gas service or utility is not on the premises of the nursing home but distributed at a central location by the local utility company. Interview with the Administrator at the time of the observation verified the natural gas is the power source utilized by the facility for their alternate source of generator power. The code requires under NFPA 99 (2012 edition)	K 918		

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K 918	Continued From page 19 Alternative Power states " ... one of more generator sets or battery systems where permitted intended to provide power during the interruption of normal electric service or the public utility electric service intended to provide power during an interruption of service normally provided by the generating facilities on premises." 2. Review of the facility contractor documentation revealed a report dated 09/04/20 stating " ... ran unit with no load." Further review of facility documents including service documents, monthly inspections, and contractor documentation revealed no evidence of a load bank test in the past three years. Interview with the Administrator on 02/22/21 at 10:30 AM revealed he/she does not have a load bank test. The code requires under NFPA 110 (2010 edition) section 7-13.4.3. that " ... a load test shall be applied for 2 hours, full load test. The building load shall be permitted to serve as part or all of the load, supplemented by a load bank of sufficient size to provide a load equal to 100% of the nameplate KW rating of the EPS." The KW rating is 15KW. 3. Observation on 02/19/21 at 9:45 AM revealed the generating room and the transfer switch room lack emergency lighting. Interview with the Administrator at the time of the observation indicated the one light in the area is not battery powered. The code requires under NFPA 110 (2010 edition)	K 918		

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K 918	Continued From page 20 " ... 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." 4. Observation on 02/22/21 at 10:25 AM revealed the generator room and transfer switch room was full of boxes, toilet chairs, equipment, and general storage. Interview with the Administrator at the time of the observation verified the observation. The code requires under NFPA 110 section 7.2.1.2. that no other equipment, except those that serve the space shall be permitted in this room."	K 918		