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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on February 26, 2021. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Three facility reported incidents were investigated (ACTS #8569, #8663, #8570). #8569 was substantiated; #8663 and #8570 were not substantiated. The highest scope and severity (S/S) = G for F689 Free of Accident Hazards/ Supervision/ Devices. Survey dates: February 22 to 26, 2021. Survey Census: 89. Sample size: 18.	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

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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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, and interview, the facility failed to protect and promote quality of life for Resident (R) 334 by ensuring that he was treated with respect and dignity. The facility failed to provide R 334, who was admitted with an in-dwelling urinary catheter (Foley) on 02/19/21, with a cover for his Foley bag (a semi-transparent bag which collects and holds urine). This deficient practice placed R334 at risk for embarrassment, and violated his privacy, having the potential to affect other residents with an in-dwelling catheter.

Findings Include:

1) An observation was made on Weinberg 1 (W1)

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F 550	Continued From page 2 on 02/22/21 at 10:04 AM. R334 was observed sitting in a wheelchair in his room, with his Foley bag hanging on his wheelchair without any cover. A small amount of dark yellow urine was visible in the Foley bag. 2) An observation was made in the W1 dining room on 02/23/21 at 08:43 AM. Physical Therapist (PT)1 was observed working with R334. PT1 left R334 sitting in his wheelchair in the dining room, with his Foley bag hanging from his wheelchair uncovered. Three other residents were in the dining room at the time. 3) Observations were made on 02/24/21 at 02:35 PM, 02/25/21 at 11:20 AM, and 02/26/21 at 07:50 AM, of R334 in his room on W1, with his Foley bag uncovered. 4) An interview was done with Registered Nurse (RN)10 in front of the W1 medication cart on 02/26/21 at 09:47 AM. RN10 stated, "we have Foley bag covers and we usually cover a resident's Foley bag on admission, whether they stay in their room, or come out, it should always be covered." RN10 further explained that both nurses and certified nurse aides are responsible for ensuring that Foley bags are covered.	F 550		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities,	F 679		

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designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure there was an ongoing resident-centered activities program that identified resident's needs; incorporate resident's interests and hobbies and failed to implement the program until four days after admission for one Resident (R)334 who resided in the yellow zone (isolation unit for persons under investigation for COVID-19. The facility failed to identify his need for social engagement. As a newly admitted resident who was physically isolated from other residents and visitors, the deficient practice resulted in feelings of loneliness and social isolation for R334 and potentially affected other residents newly admitted to the facility.
R334 is a 93-year-old male admitted on 02/19/21 and a single occupant in a room on the Weinberg 1 (W1) yellow zone, an isolation unit which housed residents whose COVID-19 status were unknown. Visitors were not allowed into the yellow zone, and residents within the yellow zone were on droplet precautions and encouraged to remain in their rooms for 14 days. Per facility policy, R334 was placed on droplet precautions, requiring a person to don (put on) a gown, gloves, N95 respirator, and a face shield or goggles, before entering his room. With the barrier of staff having to don full personal protective equipment (PPE) to enter the room, the engagement of R334 in meaningful activities was crucial to promote feelings of wellness, self-esteem, and comfort.

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F 679	Continued From page 4 Findings Include: 1) An interview was done with R334 in his room on W1 on 02/23/21 at 09:37 AM. Upon entering his room, R334 was observed sitting in his wheelchair staring out the window with the TV and radio off. During a discussion on how he was feeling, R334 said he feels like if he does not call for help, nobody bothers, and he does not have anyone to talk to. R334 went on to say that he feels it is disrespectful [for staff] not to check on him, that he would like to have someone to talk to, but he does not want "to grumble". 2) An interview was done in the W1 Dining Room with Recreation Aide (RA)1 on 02/25/21 at 11:03 AM . When asked what activities he does to engage new residents isolated in their rooms, RA1 stated, "I offer them crossword puzzles, newspapers, magazines and books. I teach them how to turn on the TV, or I turn on the radio for them." 3) Record review of R334's baseline care plan for activities notes an activities assessment was done on 02/21/21, and interventions planned based on the resident's preferences, including to "offer magazines as needed." A review of R334's Activity Participation Record notes the care plan was not implemented until two days later on 02/23/21. Further review of the Activity Participation Record notes that between 02/23/21 through 02/25/21, magazines were never offered, and the activities the resident spent the most time doing were watching the TV and listening to music in his room.	F 679		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, three residents (R) 34, R59 and R77 had one or more falls in the facility. The three residents are diagnosed with severe cognitive impairment and dependent on staff to assist with mobility. two residents are taking psychotropic medication which may cause unsteady gait and falls and have poor safety awareness and impulsiveness. The deficient practice places the residents at an increased risk for harm, requiring a higher level of staff supervision.

Findings include:

1) An initial observation of R77 was made on 02/22/21 at 12:16 PM in her room. R77 was lying in bed with the radio on, bed in the lowest position, floor mats on both sides of the bed on the floor and side rails on both sides of the bed were lowered. Surveyor asked her if she was able to reach her call light and she made a vocalization that sounded like "yes." Another observation of R77 on 02/23/21 at 07:54 AM in her room, revealed that R77 was sitting high up in bed with both side rails lowered being assisted with breakfast by the certified nurse assistant (CNA)73. The CNA73 stated that R77 liked to listen to Hawaiian music on the radio.

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R77's electronic health record (EHR) was reviewed on 02/22/21 at 1:17 PM. R77 is a 65 year old female resident with epilepsy (a central nervous system disorder causing seizures) and functional quadriplegia (complete inability to move due to a severe disability). R77's Minimum Data Set (MDS) annual assessment of 05/01/20 revealed that R77 was total dependent on one staff member to provide toileting care. A review of R77's MDS quarterly assessment of 10/30/20 revealed that R77 had declined to total dependence on two staff members to provide her toileting care. R77's care plan problem was reviewed for "Current Functional Performance - has impaired mobility due to malignant melanoma (skin cancer), quadriplegia (paralysis of all four limbs) and contracture (shortening of muscles in the limbs) to right and left legs and Alzheimer's disease." Intervention initiated for 10/30/20 stated, "Resident performance: Toilet use - Total assist/two-person physical assist."

The facility's completed Office of Health Care Assurance (OHCA) Event Report of 11/02/20 was reviewed on 02/25/21 at 11:00 AM. It stated that R77 sustained a cut to her right forehead and her nose bridge was bruised and swollen after sustaining an unwitnessed fall on 10/31/20 at 07:30 AM. R77 was lying on her left side, centered on her bed, the bed was at CNA73's waist level and both side rails were down. CNA73 turned away from R77 to obtain supplies to provide toileting care. CNA73 then heard a noise and found R77 lying on the other side of the bed on her back. There was no other CNA assisting CNA73 with R77's toileting care.

An interview was conducted with the

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Administrator on 02/26/21 at 1:33 PM in the outdoor patio of the facility. He stated that R77 has been a long time resident and that she had regular staff members care for her. No harm was meant for the resident and the fall was not anticipated.

2) Surveyor made observations on the Lehua unit in the activity/ dining room on 02/23/21 at 08:41 AM and noted R59 sitting up in a wheelchair with two clips on her shirt. CNA29 verified that they are fall alarms. She was noted to have a very dark purple colored lump on her right forehead and her eyes were closed. When asked why R59 had a bump on her forehead she verified with surveyor that R59 had a fall the previous day. At 09:51 AM R59's chair alarm sounded, and she appeared to be leaning over in her chair, restless putting her legs on the floor as if she were going to stand up. CNA29 went to R59 to help her lean back into her chair she said "I want to go take a shower" in a very low voice. At 10:03 AM a high pitched whining sound was heard from R59. CNA29 went to check on R59 stating "why you cry? and adjusted her foot rest on her w/c, surveyor noted she had a facial grimace. The CNA moved her next to the desk at the nurses station.

Surveyor reviewed the EMR for R59 on 02/23/21 at 01:33 PM. R59 is a 96 year old female admitted to facility on 10/20/20 for comfort care and Hospice, her primary diagnosis of Cerebrovascular disease and dementia. She is alert and oriented to her self only.
Progress notes dated 02/22/21: Found on the floor at 1357 by CNA, 4 x 5 centimeter (cm) hematoma to right forehead and 1.3 cm skin tear to right forearm.

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Surveyor reviewed Incident report dated 02/22/21 on 02/24/21 at 3:45 PM: Unwitnessed fall. Oriented to person. predisposing physiological factors; confused, gait imbalance and impaired memory. Predisposing situation factors; does not use call light. Root cause: is resident attempting to toilet self without using call light or notifying staff.

MDS quarterly review date 01/22/21: Brief interview for mental status (BIMS) summary score 99, (resident was unable to complete interview). Functional status: Bed mobility, transfer and toileting with extensive assistance, one person physical assist. Bladder/ Bowel: Incontinent/ continent. Fall history: one without injury and one with injury since admission. Medications: Antipsychotic, antianxiety, antidepressant and opioid use.

Care plan dated 10/20/20: Risk for falls; revision on 02/11/21. History of fall prior to admission. Resident is not able to follow directions due to dementia, resident is not calling for assistance for toileting. Resident is at risk f fall due to possible side effects from anti-depressant. Risk for impaired communication. Has moderate difficulty of hearing. No hearing aids, moderate impaired vision, no eye glasses. The resident uses psychotropic medications (Lorazepam, Risperidione, Depakote) r/t behavior management.

Surveyor interviewed RN17 on 02/26/21 at 08:58 AM. When surveyor asked her about R59's fall she stated that she wasn't working on the day she fell. R59 had a telehealth appointment the next day with her primary care physician (PCP). The CNA found her sitting on the floor mattress in her

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room, we moved her to a room closer to the nurses station after the fall. RN17 explained the follow up investigation after a resident has a fall and the care plan is updated. The nursing staff should be rounding on the resident every 2 hours at the minimum; or more if they are a high risk. They should be toileting them every few hours. The resident should be on a toileting schedule.

3) Surveyor made observations on Pikake unit on 02/22/21 at 03:31 PM. R34 was sitting up in his wheelchair in activity/ dining room at a table. He was non-verbal and wearing a mask. R34 pushed his wheelchair back from the table, turned to the left and began to stand up in his chair. CNA83 went to assist R34 and asked if he wanted a snack, he said "chocolate pudding". CNA83 stated I will get that for you in just a minute and quickly left the room. A few minutes later R34 was moving his chair and another staff approached him to ask what he needed, CNA83 proceeded to get a chocolate pudding out of the refrigerator for R34.

Surveyor reviewed R34's hard chart on 02/23/21 at 2:42 PM and noted R34 had falls in the facility on the following dates: 10/23/20; 11/27/20; 02/01/21; 02/12/21.

Surveyor reviewed the EMR on 02/24/21 at 11:44 AM. "Res is an 88 year old male with diagnosis of urinary tract infection (UTI), chronic kidney disease (CKD), Stage 3/dementia with dysphagia (difficulty swallowing) and aspiration pneumonia (PNA). Res is incontinent to both bowel and bladder. Res is total assist with bathing, dressing, grooming and toileting."

Surveyor reviewed progress notes on 02/24/21 at

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F 689	Continued From page 10 03:05 PM. 11/12/2020 at 06:46 AM. Skin tear to left lateral calf. During rounds, staff noted resident to be incontinent of urine. Staff then attempted to transfer resident from bed to wheelchair via 1 person extensive assist. Resident has difficulty standing and maintaining balance during transfer. 2nd staff attempted to assist with transfer. After the transfer was completed, staff noted that resident sustained skin tear to left lateral calf. Resident sustained skin tear measuring 5.0 X 0.7 cm. 10/23/20 at 16:12. Status post (S/P) fall. At 08:15 am, staff found resident lying down on his side on the floor (end of the bed) , naked, and leaning his head on the bed' s foot board. Resident is incontinent to bladder and bowel. Resident' s brief and bedding are wet and resident did not sleep on their shift and that he remains with intermittent yelling. Surveyor reviewed the incident report on 02/24/21 at 3:50 PM. 10/23/20: Root cause. Resident was unsupervised during event. 11/16/20 at 22:39. Resident with unwitnessed fall at 2200. Resident was put back to bed with bed in lowest position around 2000. Resident was laying in bed with episodes of yelling. Resident was last toileted by CNA at 2130. CNA reports hearing bed sensor alarm going off, when CNA got to room resident was found laying parallel to bed with right side of body and head on floor matt. Resident unable to describe events before fall. Resident alert and oriented x 1 at baseline. Resident denies pain, nausea, headache. Resident denies trying to get out of bed or reach for any belongings. Surveyor reviewed the incident report on 02/24/21 at 2:50 PM.	F 689		

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11/16/20. Root cause. Staff to pay more attention to residents yelling as this may be the first indication with alarm as the second indication that resident is moving in bed or attempting to get out of bed.

02/01/21 at 2215 S/P witnessed fall. Surveyor reviewed the incident report on 02/24/21 at 3:50 PM. 02/01/21. Root cause. Resident has a history of pushing himself away from the table in effort to achieve independence of ADL's and ambulation which is his known behavior.

2/12/2021 00:55. Unwitnessed fall. Res bed alarm alerting at 0000. Res found on floor in front of cabinet laying on right side. Res with wet brief. Res with deep purple bruise to right trochanter. Deep purple bruise noted to right outer wrist, light red bruising/ discoloration noted to spine and skin tear (ST) noted to right elbow. Surveyor reviewed the incident report on 02/24/21 at 3:50 PM. 02/12/21. Root cause: Resident is known to have a behavior to not use his call light to make his needs known. Resident does have a cognitive deficit and lacks the awareness to make safe decisions such as getting out of bed with the assistance of staff as evidence by current BIMS score of 4/15. Resident unaware to call staff for assistance, found on floor with soiled brief.

MDS quarterly assessment review date 12/24/20. Total BIMS score is 04. Functional assessment: Bed mobility, self performance is extensive assist, Staff support is two person physical assist. Toileting use: Extensive assist. Staff support is two person physical assist. Other behavioral symptoms not directed toward others, verbal/vocal symptoms like screaming, disruptive sounds. R34 is frequently incontinent and not

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participating in a toileting program.
Primary medical condition non-traumatic brain dysfunction. R34 coded with two or more falls with non-injury since admission.

Medication administration record (MAR) dated 01/21; R34 is taking anti-depressant, analgesic and anti-psychotic. (Celexa 10mg tab 1.5 in the morning for total 15 mg, Melatonin 3 mg give 2 tablet at bedtime for insomnia; RisperDAL tablet give 0.25 mg two times per day for dementia).

Care plan dated 08/26/20. Resident spends most of the day on his wheelchair. Several times throughout the day, he will attempt to stand up from his wheelchair on his own and legs come into contact with wheelchair parts causing bruising/skin tears.
Problem: Risk for Falls: Impaired cognition and forgetful, unable to comprehend use of call light for staff assistance. Resident does not seek for staff's assistance and will attempt to get out of bed by self or push self away from the table without calling for assistance. Resident needs assistance with activities of daily living (ADL's). Has episodes of yelling. Repeated falls d/t progressive dementia.
The resident uses psychotropic medications (RisperDAL)... Monitor/document/report as needed any adverse reactions of Psychotropic medications; unsteady gait...frequent falls...
Surveyor did not find monitoring flowsheet for psychotropic side effects on MAR dated 12/20 through 02/21.

Surveyor interviewed RN54 on 02/26/21 at 09:41 AM. When asked what the nursing staff is doing for fall prevention on the unit, replied that the CNA's do their rounds every 2 hours, before and

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F 689	Continued From page 13 after meals and before and after activities, we are and keeping the bed low as possible, make sure the call light is in reach and making sure their personal items are within reach. There are bed alarms if they are assessed for safety and the call light system.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement a hydration program that recognizes, evaluates, and addresses the hydration needs of every resident. This is evidenced by a failure to offer a variety of fluids during and between meals, for one resident	F 692		

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(R)334 in the sample, including the offering of alternate fluids, such as popsicles, gelatin, or ice cream.
Individuals who do not receive adequate fluids are more susceptible to urinary tract infections, pneumonia, pressure injuries, skin infections, confusion, and disorientation. R334 was not on restricted fluids and primarily isolated to his room and the facility should have ensured he was offered fluids throughout the day. As a result of these deficient practices, R334 remained at an increased risk of dehydration and has the potential to affect other residents at the facility.

Findings Include:

1) An observation and interview were done with R334 in his room on Weinberg 1 (W1) on 02/23/21 at 09:46 AM, . R334 is a 93-year-old male admitted on 02/19/21 with the diagnoses of Gram-negative Sepsis (bacterial infection of the blood), and Acute Pyelonephritis (kidney infection). He was admitted as the single occupant to a room on the W1 unit, yellow zone, an isolation unit which housed residents whose COVID-19 status were unknown. As per facility policy, R334 was primarily confined to his room for fourteen days. No water pitcher or drinking cups were noted on his bedside table, or anywhere else in his room. R334 stated that no one offers him anything to drink except what he gets with his meals.

2) An interview was done with Registered Nurse (RN) 1 in the W1 Dining Room on 02/25/21 at 10:26 AM. With regards to hydration, RN1 said all W1 residents are offered snacks and fluids at 10:00 AM and 03:00 PM daily. In addition, RN1 said if they are not on fluid restrictions (a diet

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which limits the amount of daily fluid consumption), each resident is issued a water pitcher and drinking cup upon admission. A review of R334's Electronic Medical Record (EMR) confirmed that he was not on any fluid restrictions.

3) On 02/26/21 at 11:41 AM, an observation and interview were done with Certified Nurse Aide (CNA) 50 on W1. When asked why R334 was not issued a water pitcher and drinking cup upon admission, CNA50 explained that R334 is on "nectar consistency liquids only, so he doesn't get a pitcher or cup." While reviewing how CNA50 calculates R334's fluid intake, CNA50 explained that each meal tray "comes with an eight-ounce cup of water and a four-ounce cup of juice." CNA50 confirmed that the fluid intake of "360 [mL or 12 ounces]" documented for R334 at 10:13 AM that morning was what R334 had "drank from his breakfast tray."

4) R334's daily fluid intake report from his admission on 02/19/21 to 02/26/21 was reviewed and notes only four instances out of twenty meals documented where R334 consumed more than the twelve ounces of fluid that came with his meal. Further review also notes four instances out of twenty meals documented where R334 consumed less than the twelve ounces of fluid that came with his meal. This confirms that 80% of the time, R334 consumed an amount of fluid equal to or less than the twelve ounces on his meal tray.

5) R334's Baseline Care Plan was reviewed and properly identifies him as having a "Risk for Infection" related to his diagnoses, notes a goal of "Resident Will Remain Hydrated", with a planned

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F 692	Continued From page 16 intervention to "encourage fluids...". Further review of the same care plan notes R334 was also identified as having " ...dehydration or potential fluid deficit ...".	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		

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

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, two residents (R)34 and R59 are taking psychotropic medication and have had one or more falls while residing in the facility. Both residents are at risk for side effects that may increase fall risk. The psychotropic medication review indicated both residents were not monitored for adverse effects from the medication. Gradual dose reduction was not conducted and no documentation found to provide rationale from the physician.
The deficient practice places the residents at a greater risk of injury due to the adverse effects from medications.

Findings include:

1) Surveyor made observations on Pikake unit on 02/22/21 at 3:31 PM. R34 was sitting up in wheelchair in activity/ dining room at a table, non verbal and wearing a mask. R34 pushed his wheelchair back from the table, turned to the left

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and began to stand up in chair. Certified nurse aide (CNA) 83 went to assist R34 and asked if he wanted a snack, he said "chocolate pudding". CNA83 stated I will get that for you in just a minute and quickly left the room. A few minutes later R34 was moving his chair and another staff approached him to ask what he needed, CNA83 proceeded to get a chocolate pudding out of the refrigerator for R34.

Surveyor reviewed R34's hard chart on 02/23/21 at 2:42 PM and noted R34 had falls on the following dates: 10/23/20; 11/27/20; 02/01/21; 02/12/21. (Cross reference: F689).

Surveyor reviewed the electronic medical record, (EMR) on 02/24/21 at 11:44 AM. "Res is an 88 year old male with diagnosis of urinary tract infection (UTI), chronic kidney disease (CKD), Stage 3 dementia with dysphagia (difficulty swallowing) and aspiration pneumonia (PNA). Res is incontinent to both bowel and bladder. Res is total assist with bathing, dressing, grooming and toileting."

Minimum data set (MDS) quarterly evaluation, assessment review date (ARD) 12/24/20: Brief interview for mental status (BIMS) score 4, substantial cognitive impairment. Behavioral Symptoms - Presence & Frequency; Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others). Bed mobility, Extensive assist. 2 person assist. Diagnosis: Non Alzheimer's Dementia, repeat falls. Medications: On psychotropic's on a routine basis only.

Care Area Assessment (CAA) Summary with following care areas triggered for Care plan.

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Cognitive Loss / Dementia, visual Function, communication, urinary incontinence, psychosocial Well-Being, Behavioral Symptoms, Falls, Psychotropic Drug Use.

Medication administration record (MAR) dated 01/21; R34 is taking Celexa 10 milligram (mg) tab (anti-depressant) 1.5 tab in the morning for total 15 mg; Melatonin 3 mg (an analgesic) give 2 tablet at bedtime for insomnia; and RisperDAL .25 mg (an anti-psychotic), give 1 tab two times per day for dementia.

Medication regimen review (MRR) dated 12/01/20. "Please update the care plan and add or update any physical monitors for adverse effects of RisperDAL. This resident is continuing to receive an atypical antipsychotic, please consider Labs. 1/01/21 and 01/30/21: No recommendations.
02/21/21: No recommendations to physician.

Care plan dated 08/26/20 Resident spends most of the day on his wheelchair. Several times throughout the day, he will attempt to stand up from his wheelchair on his own and legs come into contact with wheelchair parts causing bruising/skin tears.
Risk for Falls: Impaired cognition and forgetful, unable to comprehend use of call light for staff assistance. Resident does not seek for staff's assistance and will attempt to get out of bed by self or push self away from the table without calling for assistance. Resident needs assistance with activities of daily living (ADL's). Has episodes of yelling. Repeated falls d/t progressive dementia.
The resident uses psychotropic medications (RisperDAL)... Monitor/document/report as

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needed any adverse reactions of Psychotropic medications; unsteady gait...frequent falls...

Surveyor did not find monitoring flowsheet for psychotropic side effects on MAR dated 12/20 through 02/21.

2) Surveyor made observations on the Lehua unit in the activity/ dining room on 02/23/21 at 08:41 AM and noted R59 sitting up in a wheelchair. She was noted to have a very dark purple colored lump on her right forehead and her eyes were closed. When asked why R59 had a bump on her forehead she verified with surveyor that R59 had a fall the previous day.

Surveyor reviewed the EMR for R59 on 02/23/21 at 1:33 PM. R59 is a 96 year old female admitted to facility on 10/20/20 for comfort care and Hospice, her primary diagnosis of Cerebrovascular disease and dementia. She is alert and oriented to her self only.

Progress notes dated 02/22/21: Found on the floor at 1357 by CNA, 4 x 5 centimeter (cm) hematoma to right forehead and 1.3 cm skin tear to right forearm.

MDS quarterly review date 01/22/21: BIMS summary score 99, (resident was unable to complete interview). Functional status: Bed mobility, transfer and toileting with extensive assistance, one person physical assist. Bladder/ Bowel: Incontinent/ continent. Fall history: one without injury and one with injury since admission. Medications: Antipsychotic, antianxiety, antidepressant and opioid use.
Care plan dated 10/20/20:
Risk for falls; revision on 02/11/21. History of fall

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prior to admission. Resident is not able to follow directions due to dementia, resident is not calling for assistance for toileting. Resident is at risk for fall due to possible side effects from anti-depressant.
The resident uses psychotropic medications r/t behavior management. Administer psychotropic medications as ordered by physician, monitor for side effects...Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. Monitor side effects of antidepressant such as...drowsiness. Monitor side effects of anxiety medication such as blurry vision, confusion...drowsiness.
Monitor/document/report any adverse reactions of psychotropic medications: unsteady gait...frequent falls...
Risk for impaired communication. Has moderate difficulty of hearing. No hearing aids, moderate impaired vision, no eye glasses. The resident uses psychotropic medications (Lorazepam, Risperidione, Depakote) r/t behavior management.

MAR dated 02/2021: Celexa Tablet 10 mg in the evening for agitation start date 02/03/21 d/c date 02/11/21; Celexa tablet 20 mg in the evening for agitation, start date 02/11/21; Depakote 250 mg in the evening for agitation, start date 02/23/21; Risperidione tablet 1 mg at bedtime for agitation, start date, 10/20/20.

Surveyor noted interventions and effectiveness are monitored on the MAR, no documentation found that medication side effects or adverse effects are being monitored.

Medication regimen review (MRR) dated 02/21/21: Consulting pharmacist recommended

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F 758	Continued From page 22 to Nursing; please verity a physical monitor in use to record any side effects noted with use of psychoactive medications given. If side effects are noted, physician should be notified. (Celexa, Risperidione). Physician; This resident has been on the psychotropic Risperidone 1 mg every day (QD). Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective/optimal dose. Please check the appropriate response and add additional information as requested. Please review the current antidepressant therapy and provide an appropriate diagnosis for use for the following medication. Celexa. Surveyor interviewed RN17 on 02/26/21 at 08:58 AM. RN17 explained the follow up investigation after a resident has a fall involves a pharmacy review of the medications the resident is taking and any recommendations to the physician if medication changes should be considered.	F 758		
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to identify and provide food that	F 806		

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accommodates resident (R) preferences as evidenced by two (R69, and R334) of the thirty-seven residents sampled, stating they were never asked about food preferences, seven residents (R17, R42, R67, R69, R81, R333, and R334) had no documentation of their food preferences found upon record review, and one resident (R47) complained about not having his request for sunny-side eggs considered. The facility failed to identify, document, and plan for the food preferences of the residents. The facility also failed to accommodate R47's food preferences. These deficient practices have the potential to negatively impact all aspects of care, from physical, to behavioral, to psychosocial and has the potential to impact many of the residents at the facility.

Findings Include:

1) An interview was done with R334 in his room on Weinberg 1 (W1) on 02/23/21 at 09:42 AM. R334 stated no one had asked him about his food preferences, he does not get to choose his foods, he had not been given a menu, and no one had gone over a menu with him and told him how to order. Says he has "no choice but to say thank you and eat the food that I'm given."

2) An interview was done with R69 in his room on Harry Wong (HW) on 02/23/21 at 01:11 PM. R69 stated that he doesn't like the food, the food is bland, and that no one had ever asked him about his food preferences.

3) A Resident Council Meeting was conducted in the HW Activities Room on 02/24/21 at 10:51 AM with seven residents in attendance. At this meeting, R47 stated that he really missed eating

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F 806	Continued From page 24 sunny-side-up eggs. When he requested it from the Registered Dietician (RD), he was told the facility policy does not allow for undercooked eggs, and that was the end of the discussion. R47 expressed his desire to have the policy changed and stated he would address this request to the Administrator next. 4) An interview was done with the RD in the W1 Dining Room on 02/25/21 at 10:49 AM. RD says the initial attempt to obtain food preferences is through a Food Preference Form in the Admission Packet that is given either to the resident or their families upon admission. RD admits that not many of those forms are received back. However, she usually asks about food preferences at her initial dietary assessment with each resident. Once expressed, these preferences are documented either in her initial note under Assessments, or in her initial Progress Note. RD was then asked in what ways does the facility try to accommodate requests for sunny-side-up eggs. RD responded that the facility policy does not accommodate requests for undercooked eggs. 5) A review of the Electronic Health Records (EHR) for R17, R42, R67, R69, R81, R333, and R334 notes neither the Admission Nutrition Assessments, the Initial Nutrition/Dietary/Weight Progress Notes, nor the Dietary Care Plans contain any documentation regarding food preferences.	F 806		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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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 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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOLO CHINESE HOME	2459 10TH AVENUE HONOLULU, HI 96816

(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
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(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, interview, and record review, the facility failed to ensure appropriate protective and preventive measures were in place for COVID-19 and other communicable diseases and infections. This is evidenced by the facility failing to ensure staff did not move back and forth between the yellow zone, (an isolation unit which housed residents whose COVID-19 status were unknown), and green zones, (units which housed residents previously cleared of COVID-19, during the same shift. This deficient practice places the residents, healthcare personnel, and visitors to the facility are at an increased risk for unnecessary exposure, transmission, and

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development of COVID-19 and other communicable diseases and infections.

Findings Include:

1) An interview was done in the Weinberg 1 (W1) Dining Room on 02/25/21 at 11:03 AM, with Recreation Aide (RA)1. RA1 reported that he was responsible for all resident activities on the W1 unit, which had been designated a yellow zone. Surveyor visited the W1 yellow zone multiple times daily beginning 02/22/21, noting the first time RA1 was observed in the W1 yellow zone.

2) Surveyor reviewed the Recreation Aides assignment schedule found in the Activities Binder on the W1 unit for the week 02/22/21 to 02/26/21 on 02/26/21 at 11:45 AM. It was noted that RA1 was assigned to rotate between the W1 unit (yellow zone) and the Weinberg 2 (W2) unit (green zone), each day that week.

3) Review of the facility's Guidance for Staff to Minimize the Potential for Spread in The Yellow Zone and Red Zone, last updated 02/17/21, notes the following: If staff are working in the yellow zone, they should not work in the green zone as this increases the risk of transmission.

4) Surveyor made observations on the W2 on 02/25/21 at 09:48 AM. A sign was noted to be posted on the wall designating it as a "green" zone. RA1 was observed facilitating visitations on the outdoor patio.

A review of the "Activity Department - Staff Schedule 2020" was done on 02/25/21 at 10:00 AM. It revealed that RA1 was scheduled to work

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F 880	Continued From page 28 "7:30 AM - 4:00 PM" on both the "yellow" zone of W1 and the "green" zone of W2.	F 880		

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K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Management Solutions, LLC on behalf of the Department of Health, Office of Health Care Assurance on 02/24/21. Building 1 (Harry Weinberg) 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 321 SS=E	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	K 321		

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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 321	Continued From page 1 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a hazardous area had a self-closing door in the Harry Weinberg building. The deficient practice had the potential to affect five staff working in the area of the medical records storage room. NFPA 101 (2010 edition) section 19.3.2.1. Findings include: Observations on 02/24/21 at 11:05 AM revealed a hazardous area medical records storage room in the basement of the Harry Weinberg building which lacked a self-closing corridor door. The room contained eight shelves measuring eight-foot high by eight feet long full of paper storage. Interview with the Administrator at the time of the observation verified the lack of the self-closing door. The code requires under NFPA 101 (2012 edition) section 19.3.2.1. that hazardous areas are to have self-closing doors.	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	K 345		

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K 345	Continued From page 2 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke detectors were not too close to air diffusers and the facility failed to ensure smoke detection sensitivity tests had been completed within two years. The deficient practice had the potential to affect all 44 residents in the Harry Weinberg building. NFPA 72 (2010 edition) section 17.7.6.3.2 and table 14.4.2.2. Findings include: 1. Observations on 02/24/21 at 11:10 AM in the Harry Weinberg first floor dining area revealed a smoke detector within one foot of a ceiling fan. Interview with the Maintenance Director at the time of the observation verified the location of the smoke detector to the ceiling fan. The code requires under NFPA 72 section 17.7.6.3.2 " ... smoke detectors will not be located directly on the air stream of supply registers." 2. Review of the fire alarm reports revealed two smoke detection tests with report dates of 09/18/20 and 08/22/19. The reports indicated the smoke detection devices were tested but lacked ranges or readings. Interview with the Maintenance Director on 02/24/21 at 2:45 PM revealed he did not have a smoke detection sensitivity test.	K 345		

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K 345	Continued From page 3 The code requires under NFPA 72 table 14.4.2.2 that smoke detection sensitivity shall be completed every two years, and one year after a new detector is installed.	K 345		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure sprinklers were installed to provide complete coverage in one location in the Harry Weinberg building. This deficient practice has the potential to affect 20 residents. NFPA 13 (2010 edition) section 8.15.7.1. Findings include: Observations on 02/24/21 at 11:00 AM revealed	K 351		

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K 351	Continued From page 4 an exit discharge off the first floor near the yellow code area with a wooden protruding canopy measuring eight feet wide by 20 feet in length lacking sprinkler coverage. Interview with the Administrator at the time of the observation verified the canopy is lacking sprinkler coverage. The code requires under NFPA 13 (2010 edition) section 8.15.7.1. " ... sprinklers shall be installed under exterior canopies where projections exceed four feet or more in width."	K 351		
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 5 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, interview, and review of generator documents, the facility failed to ensure the 150 kW (kilowatt) diesel generator was maintained by failing to conduct a load bank test and by failing to provide emergency lighting in the transfer switch rooms. The deficient practice had the potential to affect all 44 residents in the Harry Weinberg building. NFPA 110 (2010 edition) section 17.3.4.3. and NFPA 110 (2010 edition) 7.3.2. Findings include: 1. Review of the facility contractor documentation dated 10/02/20 revealed no reference to a load bank test for the shared 150 kW diesel generator. Further review of facility documents revealed no evidence of a load bank test in the past three years. Interview with the Administrator at the time of the review revealed he does not have evidence that a load bank test was completed. The code requires under NFPA 110 (2010 edition)	K 918		

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K 918	Continued From page 6 section 7.13.4.3. " ... 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 kilowatt rating of the EPS (emergency power system.)" 2. Observations of the generating room in the basement of the Harry Weinberg building on 02/24/21 at 11:05 AM revealed the transfer switch room lacked emergency battery powered 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) " ... the level I or level II EPS 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."	K 918		

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K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Management Solutions, LLC on behalf of the Department of Health, Office of Health Care Assurance on 02/24/21. Building 2 (Harry Wong) 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 321 SS=E	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	K 321		

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K 321	Continued From page 1 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a hazardous area door had one-hour fire separation in the Harry Wong building. The deficient practice has the potential to affect 30 residents in the smoke zone from bedroom 177 to 198. NFPA 101 (2010 edition) section 18.3.2.1. Findings include: Observations of a soiled linen room on 02/24/21 at 10:15 AM in the Harry Wong building revealed a self-closing corridor door that did not have a one-hour rating. The door had a red tag with a 20-minute rating. The soiled linen room contained large quantities of soiled linen and trash storage. Interview with the Administrator at the time of the observation verified the rating on the door. The code requires under NFPA 101 (2012 edition) section 18.3.2.1. that soiled linen rooms maintain one-hour fire separation through the use of a one-hour rated corridor door.	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	K 345		

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K 345	Continued From page 2 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke detectors were not too close to air diffusers and the facility failed to ensure smoke detection sensitivity tests had been completed within two years. The deficient practice had the potential to affect all 69 residents in the Harry Wong building. NFPA 72 (2010 edition) section 17.7.6.3.2 and table 14.4.2.2. Findings include: 1. Observations on 02/24/21 9:30 to 10:15 AM in the Harry Wong building corridors revealed smoke detectors within one foot of the air diffusers in the corridor near bedroom 156, 160, 181, and 185. Interview with the Administrator at the time of the observation verified the location of the smoke detectors to the air diffusers. The code requires under NFPA 72 section 17.7.6.3.2" ... smoke detectors will not be located directly on the air stream of supply registers." 2. Review of the fire alarm reports revealed two smoke detection tests with report dates of 09/18/20 and 08/22/19. The reports indicated the smoke detection devices were tested but lacked ranges or readings. Interview with the Maintenance Director on 02/24/21 at 2:45 PM revealed he did not have a	K 345		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOLO CHINESE HOME	**2459 10TH AVENUE** **HONOLULU, HI 96816**

(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
K 345	Continued From page 3 smoke detection sensitivity test. The code requires under NFPA 72 table 14.4.2.2. that smoke detection sensitivity shall be completed every two years, and one year after a new detector is installed.	K 345		
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 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	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING **02 - BUILDING 2** B. WING _____	**02/24/2021**

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K 918	Continued From page 4 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, interview, and review of generator documents, the facility failed to ensure the 150 kW (kilowatt) diesel generator was maintained by failing to conduct a load bank test and by failing to provide emergency lighting in the transfer switch rooms. The deficient practice had the potential to affect all 69 residents in the Harry Wong building. NFPA 110 (2010 edition) section 17.3.4.3. and NFPA 110 (2010 edition) 7.3.2. Findings include: 1. Review of the facility contractor documentation dated 10/02/20 revealed no reference to a load bank test for the shared 150 kW diesel generator. Further review of facility documents revealed no evidence of a load bank test in the past three years. Interview with the Administrator at the time of the review revealed he does not have evidence that a load bank test was completed. The code requires under NFPA 110 (2010 edition) section 7.13.4.3. " ... 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 kilowatt rating of the EPS (emergency power system.)"	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 5 2. Observations of the generating room near bedroom 169 in the Harry Wong building on 02/24/21 at 10:05 AM revealed the transfer switch room lacked emergency battery powered 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) " ... the level I or level II EPS 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."	K 918		