STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING _____ B. WING _____	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A re-certification survey was conducted by the Office of Health Care Assurance (OHCA) on 03/30/21 to 04/01/21. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. OHCA also investigated the following Aspen Complaints/Incidents Tracking System (ACTS) #8676, #8346, #8719, and #8417. All allegations were not substantiated. Survey Dates: 03/30/21 to 04/01/21 Survey Census: 44 Sample Size: 12	F 000		
F 572 SS=D	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.	F 572		4/30/21

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

Electronically Signed | 04/28/2021

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F 572	Continued From page 1 (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on interview with residents, the facility failed to provide oral and written notice of rights and services prior to or upon admission for newly admitted residents. Findings Include: Cross Reference to F574 On 03/31/21 at 12:06 PM, conducted a Resident Council interview. Inquired with the residents in attendance if the facility reviewed their resident rights with them in the facility. Resident (R)110 and R46 reported they did not know if the facility reviewed the resident rights with them upon admission and while admitted to the facility. R46 also reported to this surveyor that she is blind and stated she did not receive written or oral notice of the resident rights. Conducted a record review. R110 was newly admitted on 03/10/21. During the Resident Council interview, R110 was able to respond to this surveyors questions in a cognitive and intelligent manner. Review of R46's electronic medical record (EMR) documented an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) on 02/24/21, she scored a 15 on the Brief Interview of Mental Status (BIMS), indicating the resident's cognition is intact. Review of Section B- Hearing, Speech, and Vision B1000. Vision- the ability to see in adequate light (with glasses or other visual appliances) documented R46 is severely	F 572	F572 R110 and R46 were provided the Notice of Rights and Rule [who to contact, including the Director of Social Services, Administrator and Ombudsman, if they chose to file a complaint and/or grievance; resources available (state and federal agencies). Resident R46 was given special instructions regarding accommodations available. The Director of Social Services and other clinical staff were re-educated on 4/27-30/21, of the requirements for oral and written notice of rights and services, and that Social Services would provide them prior to or upon admission for newly admitted residents. The Director of Social Services and/or designee will include in the admission packet given to residents upon admission, the Notice of Rights and Rule [who to contact, including the Director of Social Services, Administrator and Ombudsman, if they chose to file a complaint and/or grievance; resources available (state and federal agencies) as well as cover this information in the Welcome Meeting. Residents with physical disabilities and/or impairments will be given special instructions regarding accommodations available to the resident. Included in the resident education will be that no resident	

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F 572	Continued From page 2 impaired (no vision or sees only light, colors or shapes; eyes do not appear to follow objects.	F 572	will be retaliated against for asking for accommodations. The Director of Social Services and/or designee conducted a random survey of alert and oriented residents to ensure they are aware of where the information is available on the unit and who to voice their complaints, including the Ombudsman. The Director of Social Services and/or designee will ensure that this information is included in the admission packet given to residents upon admission, as well as covered orally in the Welcome Meeting, by conducting a random survey of alert and oriented residents weekly x 4 weeks, and monthly thereafter. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing	
F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and	F 574		4/30/21

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F 574	Continued From page 3	F 574		

procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.
(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and
(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
(iii) Information regarding Medicare and Medicaid eligibility and coverage;

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F 574	Continued From page 4 (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and interview with staff member and residents, the facility failed to ensure contact information for the State Long-term Care Ombudsman program and the State Agency to formally complain were provided to Resident (R)110 and R46. R110 and R46 (is severely visually impaired) reported they did not know where to find the information. Findings Include: Cross reference to F572 On 03/31/21, observed the contact information for the Ombudsman and State Agency posted on the fifth-floor bulletin board in the waiting area for the elevators. On 03/31/21 at 12:06 PM, conducted a Resident Council interview. Inquired if the residents knew where the State Agency and Ombudsman's contact information is posted. R110 and R46	F 574	F574 R110 and R46 were provided the Notice of Rights and Rule [who to contact, including the Director of Social Services, Administrator and Ombudsman, if they chose to file a complaint and/or grievance; resources available (state and federal agencies). Resident R46 was given special instructions regarding accommodations available. The Director of Social Services and other clinical staff were re-educated on 4/27-30/21, on requirements for oral and written notice of rights and services, and that Social Services would provide them prior to or upon admission for newly admitted residents . The Director of Social Services and/or designee will include in the admission packet given to residents upon admission,	

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F 574	Continued From page 5 were both not familiar with the role of the Ombudsman. Furthermore, they both did not know where to find the contact information for the Ombudsman and State Agency. During the Resident Council interview, R46 reported being blind and confirmed the facility did not provide the information in a format she could utilize. On 04/01/21 at 09:58 AM, conducted an interview with the Social Services Director (SSD). The SSD confirmed the elevator waiting area is not an area the residents frequent and would not have access to see the Ombudsman and State Agency's information.	F 574	the Notice of Rights and Rule [who to contact, including the Director of Social Services, Administrator and Ombudsman, if they chose to file a complaint and/or grievance; resources available (state and federal agencies) as well as cover this information in the Welcome Meeting. Residents with physical disabilities and/or impairments will be given special instructions regarding accommodations available to the resident. Included in the resident education will be that no resident will be retaliated against for asking for accommodations. The Director of Social Services and/or designee conducted a random survey of alert and oriented residents to ensure they are aware of where the information is available on the unit and who to voice their complaints, including the Ombudsman. The Director of Social Services and/or designee will ensure that this information is included in the admission packet given to residents upon admission, as well as covered orally in the Welcome Meeting, by conducting a random survey of alert and oriented residents weekly x 4 weeks, and monthly thereafter. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing.	
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)	F 577		4/30/21

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F 577	Continued From page 6 §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview with staff member and residents, the facility did not ensure residents are aware the results of the state inspection are available to read and easily accessible to residents as evidenced by residents two (2) residents (Resident (R)110 and R46) were unaware of where to locate the state inspection report. Findings Include:	F 577	F577 R110 and R46 were informed that the survey results are posted on the bulletin board in the dining room, as well as on the table next to the elevators. Resident R46 was given special instructions regarding accommodations available. Staff were re-educated on 4/27-30/21, regarding the need to keep the survey results readily accessible to the residents,	

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F 577	Continued From page 7 Resident Council interview was done on 03/31/21 at 12:06 PM. Inquired whether residents knew where the results of the most recent State survey is located. Residents were unaware of where to find the report to review. One out of the two residents (Resident (R) 46) interviewed during Resident Council reported being blind and would not have access to the results. On 03/31/21, observed the results of the State Agency's survey was located on the entry tables in front of the fourth and fifth floor of the elevators under two other binders (the visitor and staff sign-in binders). Concurrent observation and interview with Social Services Director on 04/01/21 at 09:58 AM, on the fifth floor confirmed the waiting area for the elevators is not an area where residents frequent. Social Services Director further acknowledged the binder of the survey results is not easily assessable under the other binders. Conducted a record review. R110 was newly admitted on 03/10/21. During the Resident Council interview, R110 was able to respond to this surveyors questions in a cognitive and intelligent manner. Review of R46's electronic medical record (EMR) documented an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) on 02/24/21, she scored a 15 on the Brief Interview of Mental Status (BIMS), indicating the resident's cognition is intact. Review of Section B- Hearing, Speech, and Vision B1000. Vision- the ability to see in adequate light (with glasses or other visual appliances) documented R46 is severely impaired (no vision or sees only light, colors or shapes; eyes do not appear to follow objects.	F 577	including those requiring special accommodations. The Director of Social Services and/or designee will include in the admission packet given to residents upon admission, the Notice of Rights and Rule where the survey results are located, as well as cover this information in the Welcome Meeting. Residents with physical disabilities and/or impairments will be given special instructions regarding accommodations available to the resident. Included in the resident education will be that no resident will be retaliated against for asking for accommodations. The Director of Social Services and/or designee conducted a random survey of alert and oriented residents to ensure they are aware of where the information is available on the unit. The Director of Social Services and/or designee will ensure that this information is included in the admission packet given to residents upon admission, as well as covered orally in the Welcome Meeting, by conducting a random survey of alert and oriented residents weekly x 4 weeks, and monthly thereafter. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing.	

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F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for	F 585		4/30/21

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F 585	Continued From page 9	F 585		

completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be

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F 585	Continued From page 10 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview with residents, the facility failed to ensure residents are aware of how to file a grievance as evidenced by Resident (R) 110 and R46 did not know how to file a formal grievance. Findings Include: Resident Council interview was done on 03/31/21 at 12:06 PM. Inquired whether residents know how to file a grievance. R110 and R46 stated they are not aware of how to file a grievance. R46 reported to this surveyor that she has voiced a few suggestions which included providing bed rails for safety and positioning, to nursing staff, but does not know if her suggestions went further than that. If R46 decided to file a formal grievance, she reported she did not know how to file a formal grievance. Conducted a record review. R110 was newly admitted on 03/10/21. During the Resident Council interview, R110 was able to respond to this surveyors questions in a cognitive and	F 585	F585 R110 and R46 were provided the Notice of Rights and Rule [who to contact, including the Director of Social Services, Administrator and Ombudsman, if they chose to file a complaint and/or grievance; resources available (state and federal agencies). Resident R46 was given special instructions regarding accommodations available. The Director of Social Services and other clinical staff were re-educated on 4/27-30/21, on the requirements for oral and written notice of rights and services, and that Social Services would provide them prior to or upon admission for newly admitted residents. The Director of Social Services and/or designee will include in the admission packet given to residents upon admission, the Notice of Rights and Rule [who to	

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F 585	Continued From page 11 intelligent manner. Review of R46's electronic medical record (EMR) documented an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) on 02/24/21, she scored a 15 on the Brief Interview of Mental Status (BIMS), indicating the resident's cognition is intact. Review of Section B- Hearing, Speech, and Vision B1000. Vision- the ability to see in adequate light (with glasses or other visual appliances) documented R46 is severely impaired (no vision or sees only light, colors or shapes; eyes do not appear to follow objects.	F 585	contact, including the Director of Social Services, Administrator and Ombudsman, if they chose to file a complaint and/or grievance; resources available (state and federal agencies) as well as cover this information in the Welcome Meeting. Residents with physical disabilities and/or impairments will be given special instructions regarding accommodations available to the resident. Included in the resident education will be that no resident will be retaliated against for asking for accommodations. The Director of Social Services and/or designee conducted a random survey of alert and oriented residents to ensure they are aware of where the information is available on the unit and who to voice their complaints, including the Ombudsman. The Director of Social Services and/or designee will ensure that this information is included in the admission packet given to residents upon admission, as well as covered orally in the Welcome Meeting, by conducting a random survey of alert and oriented residents weekly x 4 weeks, and monthly thereafter. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		4/30/21

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KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

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F 655	Continued From page 12	F 655		

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be

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F 655	Continued From page 13 administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview with staff member, the facility failed to ensure pain management was included in resident (R)259's baseline care plan to provide effective and person-centered care that meets professional standards of quality care. The deficient practice resulted in unmanaged pain for R259. Findings Include: Cross Reference to F697. R259 was admitted on 03/26/21 with diagnosis of multiple fractures of ribs, unspecified side, subsequent encounter for fracture with routine healing, unspecified fracture of sacrum, sequela (an aftereffect of a disease, condition, or injury), and subsequent encounters of contusion and laceration of left cerebrum (located in the front area of the skull) without loss of consciousness, contusion of left front wall of thorax (the chest region of the body between the neck and the abdomen, along with its internal organs and other contents), and unspecified injury of head. Within 48 hours of admission, R259 was prescribed with Acetaminophen Tablet 500 milligrams (mg) one tablet every eight hours for pain, Acetaminophen Tablet 325 mg two tablets every six hours as needed for pain (not to exceed 3000 mg in 24 hours), and Lidoderm Patch 5% to be applied to right ribs and left hip topically every morning for pain management.	F 655	F655 Although R259 did not have pain listed on her Baseline Care Plan, she still received pain management therapies. Clinical staff were inserviced on 4/27-30/21, of the need to have Baseline Care Plans completed within 48 hours of admission, that address the medical diagnosis including but not limited to skin, falls, ADLs, and Pain. The Director of Nurses and/or designee checked all residents on pain medication to ensure their Baseline Care Plans addressed the medical diagnosis including but not limited to skin, falls, ADLs, and Pain. The Director of Nurses and/or designee will conduct an audit of all residents on pain medication to ensure Baseline Care Plans addressed the medical diagnosis including but not limited to skin, falls, ADLs, and Pain, biweekly x 2 weeks, weekly x 4 weeks, and monthly x2 to ensure there are no deficient practices. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing	

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F 655	Continued From page 14 On 03/31/21 at 08:05 AM and 02:24 PM and on 04/01/21 at 06:59 AM and 07:22 AM, observations were made of R259 verbal expressed pain with facial grimacing and agitation. On 04/01/21 at 11:32 AM, reviewed R259's baseline care plan with the Director of Nursing (DON). R259's baseline care plan did not include pain, despite being admitted with multiple injuries and medications for pain. The DON confirmed a resident admitted with multiple fractures who was admitted on pain medication should have been monitored for pain. R249's pain was not being monitored.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		4/30/21

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F 656	Continued From page 15 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record reviews and a family interview, the facility failed to develop and implement a comprehensive person-centered care plan for resident (R)56 in collaboration with hospice services. As a result of this deficiency, all hospice residents are at risk of the potential for a negative impact on residents. Findings Include: Cross Reference to F656 R56 is 91-year-old male who was admitted for hospice care on 03/05/21. On 03/31/21 at 08:26, during a family interview	F 656	F656 R56□'s 54-page Comprehensive Person-Centered Hospice Care Plan was received and put into the facility chart on 3/31/21. Island Hospice IDT Notes: The hospice nurse documented on 3/6/21: "Pt's granddaughter Trudy updated." 3/7/21: "Pt.s granddaughter Trudy contacted and she states she visited patient this morning and is aware of constipation. Trudy says she forgot to sign ACR form." The Director of Social Services and other clinical staff were re-educated on	

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F 656	Continued From page 16 (FI), the family member (FM) stated she did not know if there was a hospice nurse involved. On 03/31/21 at 02:15 PM, record review (RR) revealed no care plan in the electronic medical record. RR of the Hospice binder revealed one page of notes by hospice provider of interdisciplinary progress note. Interview on 03/31/21 at 02:20 PM with Unit Manager (UM) confirmed that there was no care plan and was apologetic. UM stated, "we were working on it last week and somehow, it did not get into the system."	F 656	4/27-30/21,on the referral and admission protocol for hospice residents. Protocol: The referral is sent to the resident/family by hospice liaison. Hospice nurse consultant conducts an evaluation, resident/family sign contract to proceed. Physician order for hospice is received. The Director of Social Services and/or designee will request a comprehensive person-centered hospice care plan within 24-hours of admission, as well as complete a facility hospice care plan. The Director of Social Services and/or designee conducted an audit of all hospice residents to ensure the comprehensive person-centered hospice care plan and facility□'s hospice care plan was in the resident□s chart. The Director of Social Services and/or designee will conduct an audit of all hospice residents to ensure the comprehensive person-centered hospice care plan and facility□'s hospice care plan is in the resident□s chart; that there is coordination and communication between hospice and facility, weekly x 4 weeks, monthly thereafter. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		4/30/21

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F 657	Continued From page 17 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, interview with staff, and record review, the facility failed to ensure the comprehensive care plan were reviewed and revised for two of 12 residents (Resident (R)15 and R259) selected for review. Evidenced by R15's care plan related to dementia care was not revised to include person-centered interventions and R259's comprehensive person-centered care plan was not reviewed and revised after developing a facility acquired pressure injury. As	F 657	F657.1 The Director of Social Services reviewed and updated R15'□s care plan to reflect current person-centered interventions during the annual survey on 4/27/21. The Director of Social Services and other staff were re-educated on 4/27-30/21, of the need to review and update Care Plans as residents□ condition and needs	

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F 657	Continued From page 18 a result of this deficient practice, interventions to promote healing of a facility acquired pressure in prescribed by the physician were not and interventions for person-centered interventions were not implemented. As a result of this deficiency, residents are at risk of a potential negative impact. Findings Include: 1) R15 was admitted to the facility on 07/13/20 with diagnoses that included dementia without behavioral disturbances. On 03/31/21 at 08:31 AM, conducted a review of R15 electronic medical record (EMR). Review of R15's care plan related to dementia documented the care plan was initiated on 07/13/20. The goals for R15's dementia included R15 will be able to communicate basic needs on a daily and the resident will maintain her current level of cognition were both initiated on 07/14/20 with a target date of 01/14/21. The only intervention was listed, to administer medications as ordered and monitor/document was initiated on 07/13/20. On 04/01/21 at 09:33 AM, conducted an interview with the Director of Nursing (DON) regarding R15's care plan related to dementia care. The DON confirmed R15's care plan related to dementia care was not updated or revised to reflect the person-centered dementia care the resident is currently receiving. 2) Cross Reference to F686. Review of R259's physician's order on 03/30/21, "Float heels and apply heel protectors while in bed every day and night shift ..."	F 657	change. The Director of Social Services reviewed the other residents on psycho/social needs, dementia/cognitive behaviors and updated theirs care plans to reflect current person-centered interventions on 4/27/21. The Director of Social Services will review the initial and quarterly Comprehensive Care Plans of residents on psycho/social meds, dementia/cognitive behaviors to ensure they reflect the resident'□s current person-centered interventions, biweekly x 2 weeks, weekly x 4 weeks, monthly thereafter. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing. F657.2 Resident R259'□s Kardex was reviewed and updated on 4/5/21. The clinical staff were re-educated on 4/27-30/21; nurses on the use of the Care Plans and the need to complete and update the Kardex; the CNAs on the need to check the Kardex for how they are to meet the resident'□s needs, including but not limited to specifics such as properly applying heel protectors and floating heels. All other residents with skin impairment Kardex were reviewed and updated if necessary on 4/5/21.	

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F 657	Continued From page 19 Review of wound evaluation dated on 03/29/21 the goal of care is to "Monitor/Manage" and to "Monitor for any signs of skin breakdown. Elevate heel at all times to prevent further skin breakdown." Review of R259's care plan initiated on 03/26/21 and last revised on 03/29/21, was not revised to develop interventions for healing and preventing of worsening of the pressure injury as reflected by the physician's order on 03/30/21 and wound evaluation on 03/29/21. Observed on 03/31/21 at 08:07 AM and on 04/01/21 at 07:25 AM and 09:50 AM, R259's heels were not floating. The facility did not implement the physician's order.	F 657	The Director of Nurses and/or designees will conduct audits on residents with skin impairments to ensure the Care Plans are current, the resident□'s Kardex are current and observe that staff are carrying out the Care Plans. Audits will be conducted biweekly x 2, weekly x 4 and monthly for 2 months to ensure there are no deficient practices. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record reviews and a family interview, the facility failed to develop and implement a comprehensive person-centered care plan for resident (R)56 in collaboration with hospice services. As a result of this deficiency, all hospice residents are at risk of the potential for a	F 684	F684 The 54-page Comprehensive Person-Centered Hospice Care Plan was received for R56 and put into the facility chart on 4/1/21.	4/30/21

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F 684	Continued From page 20 negative impact on residents. Findings Include R56 is 91-year-old male who was admitted for hospice care on 03/05/21. On 03/31/21 at 08:26, during a family interview (FI), the family member (FM) stated she did not know if there was a hospice nurse involved. She also stated "I'm worried about his teeth. He can't swallow. He doesn't have his dentures in. I noticed during a couple of visits; his gums are not clean. It looks like his gums are a little puffy and starting to bleed. I didn't get a chance to talk to the nurses about this because my visit was over." On 03/31/21 at 02:15 PM, record review (RR) revealed no care plan in the electronic medical record. RR of the Hospice binder revealed one page of notes by hospice provider of an interdisciplinary progress note. The Minimum Data Set (MDS) which entails a comprehensive, standardized assessment of each resident's functional capabilities and health needs was reviewed. The MDS stated R56 showed inflamed or bleeding gums or loose natural teeth. Furthermore, R56 had mouth or facial pain, discomfort, or difficulty with chewing. Interview on 03/31/21 at 02:20 with Unit Manager (UM) confirmed that there was no care plan and UM was apologetic. UM stated "we were working on it last week and somehow, it did not get into the system." The quality of care for R56 is compromised because there is no care plan or evidence to show collaboration between hospice, facility,	F 684	Island Hospice IDT Notes: The hospice nurse documented on 3/6/21: "Pt's granddaughter Trudy updated." 3/7/21: "Pt.s granddaughter Trudy contacted and she states she visited patient this morning and is aware of constipation. Trudy says she forgot to sign ACR form." The Director of Social Services and other clinical staff were re-educated on 4/27-30/21, on the referral and admission protocol for hospice residents. Protocol: The referral is sent to the resident/family by hospice liaison. Hospice nurse consultant conducts an evaluation, resident/family sign contract to proceed. Physician order for hospice is received. The Director of Social Services and/or designee will request a comprehensive person-centered hospice care plan within 24-hours of admission, as well as complete a facility hospice care plan. The Director of Social Services and/or designee conducted an audit of all hospice residents to ensure the comprehensive person-centered hospice care plan and facility□s hospice care plan was in the resident□s chart. The Director of Social Services and/or designee will conduct an audit of all hospice residents to ensure the comprehensive person-centered hospice care plan and facility'□s hospice care plan is in the resident□'s chart; that there is coordination and communication between hospice and facility, weekly x 4 weeks,	

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F 684	Continued From page 21 and/or family member. The facility has failed to provide the fundamental principle that applies to all treatment and care for R56. This deficient practice has the potential to affect all the residents in the facility.	F 684	monthly thereafter. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview with staff members, the facility failed to ensure Resident (R)259 was provided treatment to promote healing of a facility acquired deep tissue injury to the right heel. As a result of this deficiency, the resident as the potential to experience more than minimal harm. Findings Include: Cross Reference to F657. Review of R259's "Skin & Wound Evaluation" on	F 686	F686 Resident R259'□s Kardex was reviewed and updated to on 4/5/21. The licensed staff was re-educated on 4/27-30/21: nurses on use of the Care Plans and the need to complete and update the Kardex; the CNAs on the need to check the Kardex for how they are to meet the resident□'s needs, including but not limited to specifics such as properly applying heel protectors and floating heels.	4/30/21

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F 686	Continued From page 22 03/29/21 indicated R259 has a pressure deep tissue injury to right heel acquired at facility. The notes included "Float heels and apply heel protectors while in bed check for position ..." On 03/30/21 R259's doctor also ordered, "Float heels and apply heel protectors while in bed every day and night shift ..." Initial observation on 03/31/21 at 08:07 AM while Certified Nursing Assistant (CNA)25 and CNA26 were changing R259's bed linens. Observed R259 wearing purple foam heel protectors on both feet and a pillow underneath the knees. The resident's heels were in contact with the bed mattress. A second observation on 04/01/21 at 07:25 AM while CNA28 and Registered Nurse (RN)13 were repositioning R259 to take medication and eat breakfast. Observed R259's right heel protector not applied and on the bed. The left heel protector was not applied on the heel and located on the left calf. R259 was positioned lying on the right side with a pillow between the knees and lateral heels touching the mattress. Concurrent observation on 04/01/21 at 09:50 AM with RN13, R259 had a pillow underneath the knees. RN13 confirmed R259 is wearing heel protectors because there is a pressure injury on the right heel. Surveyor asked RN13 what it meant for R259's heels to float, RN13 reported the heels are not to touch the bed and proceeded to move the pillow underneath the knees and place it under R259's calves. RN13 confirmed R259's heels were not floating when the pillow was underneath the knees.	F 686	All other residents with skin impairment Kardex were reviewed and updated if necessary on 4/5/21. The Director of Nurses and/or designees will conduct audits on residents with skin impairments to ensure the Care Plans are current, the resident□'s Kardexes are current and observe that staff are carrying out the Care Plans. Audits will be conducted biweekly x 2, weekly x 4 and monthly for 2 months to ensure there are no deficient practices. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing.	

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(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 697	Continued From page 23	F 697		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, policy review and interview with staff members, the facility failed to recognize and provide effective pain management to Resident (R)259 and R109. The deficient practice resulted in R259 yelling pain, making grimacing facial expressions, and irritability when repositioned during meals and medication administration. The deficient practice also resulted in R109's pain not managed, monitored or evaluated according to standards of practice. These deficient practices have the potential to affect other residents' pain management in the facility. As a result of this deficiency, residents have the potential for more than minimal harm. Findings Include: Cross Reference to 655 1) R259 was admitted on 03/26/21 with diagnosis of multiple fractures of ribs, unspecified side, subsequent encounter for fracture with routine healing, unspecified fracture of sacrum, sequela (an aftereffect of a disease, condition, or injury), and subsequent encounters of contusion and laceration of left cerebrum (located in the front area of the skull) without loss of consciousness,	F 697	F697.1 The Director of Nurses reviewed the resident□s pain levels and medication administration. Staff monitored resident from March 26, 2021 [date of admission]. Pain scale noted were 0-2. On 4/1/21, pain score documented at 8 so in addition to the routine Acetaminophen and Lidoderm Patch 5%, the resident was given Oxycodone 2.5 mg PO. Resident was continued to be monitored for pain. PRN Morphine Sulfate 20 mg/ml 05 ml ordered for moderate/severe pain beginning on 4/2/21. Pain management training was conducted 4/27-30/21, on medication for pain management, including the use of non-pharmacological interventions and the efficacy and effectiveness of the interventions. The Director of Nurses and/or designee identified current residents on medication for pain management, including the use of non-pharmacological interventions and the efficacy and effectiveness of the interventions. There were no other	4/30/21

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F 697	Continued From page 24 contusion of left front wall of thorax (the chest region of the body between the neck and the abdomen, along with its internal organs and other contents), and unspecified injury of head. R259 is prescribed with routine Acetaminophen Liquid 160 milligrams (MG)/5 milliliters (ML), give 20 ML by mouth three times a day for pain, Acetaminophen Liquid 160 MG/5 ML, give 20 ML by mouth every 4 hours as needed for pain (not to exceed 3000 MG in 24 hours), Lidoderm Patch 5% to be applied to right ribs and left hip topically every morning for pain management, and Oxycodone Hydrochloride 5 MG, give 2.5 MG by mouth every 6 hours as needed for severe pain. On 03/31/21 at 08:05 AM, observed R259 in bed facial grimacing and saying " ...owie ..." repeatedly. This surveyor used the call light for staff assistance and waited outside of R259's room. At 08:07 AM, the Activities Coordinator answered the call light, checked on R259, and sought assistance from nursing staff. This surveyor returned to R259's room and found Certified Nursing Assistance (CNA)25 and CNA26 repositioning R259 and changing her bed linens. R259 continued to facial grimace and repeatedly say "...owie ..." CNA25 and CNA26 explained that R259 is in pain because earlier it took multiple attempts to reinsert the intravenous (IV). As R259 continuously expressed pain, CNA25 and CNA26 asked R259 where the pain is and R259 yelled " ...my leg ..." followed by " ...owie ..." A second observation on 03/31/21 at 02:24 PM, R259 was lying in bed and appeared upset with facial grimacing. In a loud voice, R259 yelled "...owie, owie ...I'm hurting!" This surveyor left the	F 697	residents found to be deficient. The Director of Nurses and/or designee will audit residents on pain management for appropriateness and effectiveness of the interventions, including the use of non-pharmacological interventions and the efficacy and effectiveness of the interventions,biweekly x 2, weekly x 4 and monthly x 2. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing. F697.2 R109 had a lidocaine patch that was coming off, so the nurses replaced the patch. The nurse did not feel this was a new patch, but rather a replacement, therefore the nurse did not believe another evaluation was required. This was a routine order to be applied once daily. Follow up pain assessments are completed on PRN pain interventions. Pain management training was conducted 4/27-30/21, on medication for pain management, including the use of non-pharmacological interventions and the efficacy and effectiveness of the interventions. The Director of Nurses and/or designee identified current residents on lidocaine patch for pain management, including the use of non-pharmacological interventions and the efficacy and effectiveness of the	

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F 697	Continued From page 25 room to look for assistance from nursing staff. When nursing staff was not seen this surveyor re-entered R259's room and R259 stated "I am hurting, I am hurting!". This surveyor stepped out of the room again to look for nursing staff and found Certified Nursing Assistant (CNA) 27 making rounds to check vital signs. Surveyor informed CNA27 that R259 is yelling out in pain and if CNA27 can inform the nurse. CNA27 stated she will go check on R259. A few moments later CNA27 returned to this surveyor and reported R259 was okay. Concurrent review of the Medication Administration Record (MAR) on 04/01/21 at 09:55 AM with Registered Nurse (RN)13. On the day R259 was observed in pain and CNA27 reported R259 was okay, 03/31/21, R259 did not receive any PRN (as needed) medication, Acetaminophen or Oxycodone. On 04/01/21 at 06:59 AM observed R259 lying in bed and repeatedly loudly "I want to stop the pain ..." During this time, a nursing staff was helping R259's roommate with care. On 04/01/21 at 07:22 AM, R259 could be heard from the fifth-floor dining area, R259 yelling "stop the pain" repeatedly from the room. At 07:25 AM, RN13 entered R259 ' s room and provided Oxycodone as needed for pain. As CNA28 attempted to adjust R259's bed for RN13 to safely administer R259 pain medication, R259 appeared to be facial grimacing, agitated, and repeatedly stated " ...ow ..." RN13 explained it will take about 30 minutes for the pain medication to start working. At 7:33 AM, CNA28 asked if R259 wanted to eat breakfast now or later. R259 continued to express pain through facial	F 697	interventions. There were no others found to be deficient. The Director of Nurses and/or designee will audit residents on pain management for appropriateness and effectiveness of the interventions, including the use of non-pharmacological interventions and the efficacy and effectiveness of the interventions, biweekly x 2, weekly x 4 and monthly x 2. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing.	

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grimacing, verbal cues and agitation as CNA28 attempted to adjust R259's bed for breakfast. After multiple attempts with adjusting the bed CNA28 explained to R259 that she will come back in 15 minutes to assist with breakfast.

2) Interview on 03/30/21 at 09:28 AM with resident (R)109 who stated "I have pain in my back and left lower back and I am taking codeine for it. It works to a point but three or four hours later, it wears off and I can only take four a day." They put the patch on two hours ago." R109 rated his pain 5/10 on the Wong-Baker FACES pain rating scale.

Observation at 09:40 AM on 03/30/31 of R109 patch site revealed no patch on R109's back. Instead, the patch was stuck to the sheets.

Interview on 03/30/21 at 09:50 with registered nurse (RN)8 who confirmed that the patch was not on R109's back. RN8 came back with a new patch and applied to R109's back.

On 03/30/21 record review (RR) at 10:00 AM showed orders to question resident about presence of pain or burning including pressure points. Monitor for pain using 0-10 scale. 0 for no pain, 10 for worst pain possible. If resident is not able to answer, use pain scale.
RR revealed an order for lidocaine pain relief patch 4%. Apply patch to left lower back topically one time a day for compression fractures (12 hours on and 12 hours off.
Another order to record non-pharmacological pain:
1=repositioning/limb, elevation
2=reassurance/emotional support
3=distraction/diversionary activities

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4=ROM/ambulation/stretching
5=rest period/quiet environment
6=deep breathing/relaxation exercises
7=massage/therapeutic touch
8=application of ice/heat pack
9=laughter/socialization.
10=Aroma therapy
11=NO PAIN PRESENT
EVALUATION OF PAIN IN VITALS, UNDER PAIN
-
Evaluation of pain, located in vitals under pain in the electronic medical records shows inconsistent documentation of pain in relation to administration and follow-up of pain medication as below:
3/30/2021 16:10 0 Numerical RN8 (Manual)
3/30/2021 14:19 0 Numerical RN8 (Manual)
3/30/2021 08:35 0 Numerical RN8 (Manual)

RR of electronic administration record reveals that the first lidocaine patch was placed at 0800 AM and evaluated at 8:35 AM. The level of pain was recorded at 0. A replacement pain patch was placed on R56 at approximately 10:00 AM on 03/30/21. There was no pain evaluation done for the replacement patch. The next evaluation of pain was documented at 03/30/21 at 14:19 PM by RN8.

Record review of policy and guidelines, dated 11/2017, on 03/31/21 at 1400 for Quality of Care for Pain Management was done. Policy for pain management states "The resident will be monitored for the presence of pain and be evaluated when there is a change of condition and whenever there is new pain or exacerbation of pain is suspected. (d) Monitor appropriately for effectiveness and/or adverse consequences (e.g., constipation, sedation) including defining how and when to monitor the resident's

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F 697	Continued From page 28 symptoms and degree of pain relief; and modify the approaches as necessary.	F 697		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, the facility failed to label an intravenous medication tubing in accordance with professional principles and cautionary instructions. Label did not include an expiration date for R109.	F 761	F761 The licensed nurses were educated on Nurses 4/27/21 & 4/29/21, of the need to label not only the IV bag, but also the tubing.	4/30/21

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F 761	Continued From page 29 Findings Include: On 03/31/21 at 10:00 AM, an intravenous (IV) antibiotic was hanging on IV pole with a medication bag labeled Ceftriaxone 2000 mg, administer 50 milliliters over 30 minutes, every 24 hours until 04/31/21. Interview on 03/31/21 at 10:05 AM with Registered Nurse (RN)8 who confirmed that IV tubing is good for 24 hours and the label was not on tubing. Policy review on 03/31/21 of Parenteral and IV fluids, Number 694 states The facility will provide parenteral fluids consistent with professional standards of practice, including competent staff, in consideration of the resident's plan of care, accepted infection control practices and monitoring for complications. Interview with Director of Nursing (DON) on 04/01/21 at 11:00 whom provided policy for IV fluids. DON stated the IV tubing is good for 24 hours.	F 761	R109□s IV tubing was labeled on 3/31/21. Residents with IVs were audited and tubing labels checked. There was no other deficient practice. The Director of Nurses and/or designee will audit all IV tubing for labels biweekly x 2, weekly x 4 and monthly x 2. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing.	
F 812 SS=D	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	F 812		4/30/21

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F 812	Continued From page 30 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 and interview with staff member, the facility failed to ensure food products were stored under sanitary condition and discarded before the expiration date as evidenced by a bowl stored in an opened bag of flour and expired Thickened Cranberry Cocktail. Findings Include: On 03/30/21 at 08:25 AM, during the initial kitchen tour with Kitchen Manager (KM), the dry goods storage room had four boxes of Ready-Care Thickened Cranberry Cocktail with the use by date of 03/20/21. KM stated the items came in this morning and usually does a daily walk through to check for expired items. KM also stated dry goods should be discarded by use by dates. Observation also found a bowl stored in a bag of opened flour. KM did not respond when asked if the bowl should be there and proceeded to grab the bowl from the bag of flour and walked away.	F 812	F812 The expired cranberry cocktail was disposed of immediately. No expired product was sent to the units and/or used. The scoop was removed from the flour bin when it was discovered. Dietary staff were educated on March 30, 2021, on the need to check the expiration dates on all products being received at the time of delivery as well as those in storage. Also, that equipment used for scooping food are not to be stored in food containers. Same as above. The Director of Dietary Services and/or designee will conduct Daily Quick Checklist audits which includes outdated food, items stored in the storeroom; checking that no equipment is stored in the food containers. This procedure will be conducted daily and ongoing. The results of the audits will be reported to the Quarterly Quality Improvement	

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F 812	Continued From page 31	F 812	Committee as well as the Governing Board. 4/30/2021 and ongoing	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to	F 849		4/30/21

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provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

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(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those

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residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a

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	125066	A. BUILDING _____ B. WING _____	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	1723 KALAKAUA AVENUE HONOLULU, HI 96826

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 849	Continued From page 35 description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. Facility failed to arrange provision and obtain the hospice plan of care specific to R56, hospice election form, physician certification and recertification of the terminal illness specific for R56. Findings Include: On 03/31/21 at 11:06 AM, observation of R56 revealed resident calling out "I'm dying." Nurse stated that she just medicated him. On 03/31/21 at 08:26 AM, during a family interview (FI), the family member (FM) stated she did not know if there was a hospice nurse involved. On 03/31/21 at 1:03 PM, conducted an interview with LPN2 and concurrent review of hospice records. R56's hospice records was composed of only RN notes and a paper of the coordinated plan of care template which was signed by hospice nurse and facility nurse. RR of the Hospice binder revealed one page of notes by hospice provider of interdisciplinary progress note. Surveyor queried regarding any other hospice documentation, specifically the Hospice plan of care, election form, any advance directives, physician certification and	F 849	F849 The 54-page Comprehensive Person-Centered Hospice Care Plan was received for R56 and put into the facility chart on 3/31/21. This included the physician certification of the terminal illness. Island Hospice IDT Notes: The hospice nurse documented on 3/6/21: "Pt's granddaughter Trudy updated." 3/7/21: "Pt.s granddaughter Trudy contacted and she states she visited patient this morning and is aware of constipation. Trudy says she forgot to sign ACR form." The facility has a contract with Islands Hospice on file. A copy was provided to the surveyor, along with 3 other hospice agencies. The Director of Social Services and other clinical staff were re-educated on the referral and admission protocol for hospice residents on 4/27-30/21. Protocol: The referral is sent to the resident/family by hospice liaison. Hospice nurse consultant conducts an evaluation, resident/family sign contract to proceed. Physician order for hospice is received. The Director of Social Services and/or designee will request a comprehensive	

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F 849	Continued From page 36 recertification of terminal illness specific for R56. No other documentation or evidence of electronic care plan was available. Interview on 03/31/21 at 1:23 PM with the DON, who concurrently went through records that revealed admission paperwork from queens but no hospice paperwork. R56 had been in the facility for approximately 21 days with no care plans for hospice care. This deficient practice can potentially affect other residents in the facility.	F 849	person-centered hospice care plan within 24-hours of admission, as well as complete a facility hospice care plan. The Director of Social Services and/or designee conducted an audit of all hospice residents to ensure the comprehensive person-centered hospice care plan and facility□s hospice care plan, certification and recertification of the terminal illness, was in the resident□s chart. The Director of Social Services and/or designee will conduct an audit of all hospice residents to ensure the comprehensive person-centered hospice care plan and facility□s hospice care plan, that there is coordination and communication between hospice and facility, certification and recertification of the resident□s terminal illness, is in the resident□s chart, weekly x 4 weeks, monthly thereafter. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing.	
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.	F 919		4/30/21

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F 919	Continued From page 37 §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents call light system is properly working and relayed in a centralized staff work area. As a result of this deficiency, residents are at potential risk for falls and/or injury. Findings Include: 1) Interview on 03/30/21 at 09:20 AM with R109 stated "I press the button and it could take 20 minutes to half an hour before they come." I told them, "Hey what you want me to do, do it in bed, walk there myself?" My main concern is someone should be there. The other day, I walked in the restroom myself. The worker came and I told them, it was too late. 2) Interview on 03/30/21 at 10:29 AM with R110 who stated it takes at least 20 minutes for the call light. I think the aide, or the nurses have eleven rooms. This morning, the call light was not working, so the nurse's aide went room to room. 3) On 03/30/21 at 12:16 PM, observed a contractor with a Johnson Controls uniform on the fifth floor in front of the elevators. Inquired about his presence at the facility and the contractor explained that the residents call light system is not working properly. The contractor stated the lights outside the resident's rooms are working but the call system is not transmitting to the Nurse's station. Administrator (ADMIN) further explained that the residents call light system was not transmitting to the Nurse's station on all units	F 919	F919 Environmental services did issue a report that the call light system was not working properly and called the service vendor the same day. Parts were ordered; and system was repaired on April 6, 2021. System was tested and vendor validated it operational. Although the call lights were operational in the hallway, additional action was required. In addition to informing staff to make 15-minute rounds on all residents, call bells had been issued to each resident on March 31, 2021. This is the emergency plan when the facility experiences a power failure. Staff were inserviced on the need to better communication when the call lights have any mechanical problems on 4/27-30/21. Back-up bells will be issued. Will continue to conduct 15-minute rounds to ensure resident needs are being met. In the future, when the call light system experiences another mechanical problem, Environmental Services is notified, and staff will be informed to use the back-up emergency plan to ensure residents needs are being met on a timely basis. The Director of Nurses and/or designee will audit the implementation and effectiveness of this plan during the entire	

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F 919	Continued From page 38 and nursing staff was instructed to check on residents more often. During Resident Council interview on 03/31/21 at 12:06 PM, Resident (R) 110 stated since Monday, 03/29/21, the "...buzzard don't work" and so they are waiting about 25 to 45 minutes for nursing staff to respond. R110 further explained that if nursing staff are not in the vicinity of the rooms they do not know if a resident is calling for assistance. R46 agreed that nursing staff have been taking a long time to respond to their call light since Monday.	F 919	time the system is down, until the system is repaired. The results of the audits will be reported to the Quarterly Quality Improvement Committee as well as the Governing Board. 4/30/2021 and ongoing.	

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E 000	Initial Comments A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on 03/30/21 to 04/01/21. The facility was found to be in substantial compliance with Appendix Z, Emergency Preparedness, §42 CFR 483.73 for long term care facilities.	E 000		

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

Electronically Signed | 04/28/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. BUILDING **01 - KALAKAUA GARDENS** B. WING _____	**08/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALAKAUA GARDENS	**1723 KALAKAUA AVENUE HONOLULU, HI 96826**

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K 000	INITIAL COMMENTS A Life Safety Code (LSC) survey was conducted by Healthcare Management Solutions, LLC on behalf of the Department of Health, Office of Health Care Assurance on August 16, 2021. The Facility was found not to be in compliance with the requirements of 42 CFR 483.90, 2012 Edition of the Life Safety Code for Long Term Care Facilities. The facility is a 17-story building with two certified floors. The fourth and fifth floors are skilled nursing. The sixth floor is memory care assisted living. Floors seven through 10 are assisted living and floors 11-17 are independent living. The facility was constructed in 2016 of concrete roofing, concrete flooring, and concrete bearing walls. The facility has a 450 KW diesel generator that supplies back up power to the entire building.	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A	K 321		9/30/21

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

Electronically Signed | 09/18/2021

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

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K 321	Continued From page 1 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 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview with the Environmental Services Director (ESD), the facility failed to ensure that hazardous area enclosures resist fire for up to 3/4 hour in accordance with NFPA 101 8.7.1.1. (2012 edition). This deficient practice had the potential to affect all 42 residents on both the 4th and 5th floors. Findings include: Observation of the fifth-floor soiled linen closet near bedroom 508 in the main exit access corridor on 08/16/21 at 10:50 AM revealed the room contained one 5 foot (ft) high by 3 ft. wide soiled linen transport cart half full of soiled linens and one 55-gallon red biohazard trash container. The rating door tag revealed the door was a 20-minute door. The door was lacking a fire rated door of at least 3/4 hour. Observation of the fourth-floor soiled linen closet near bedroom 408 in the main exit access corridor on 08/16/21 at 11:40 AM revealed the room contained one 5 ft. high by 3 ft. wide soiled	K 321	K321 Servdor was contacted on 8/19/21 and proposal for doors were received on 9/13/21. Corrective Action: Fire rated doors of 3/4 hour for: a) 5th floor soiled linen closet near 508, b) 4th floor soiled linen closet near 408, and c) 4th floor medical records storage area near 410, were ordered on 9/13/21. Due to the COVID pandemic and issues with shipping from the U.S. Mainland, delivery date is expected by 11/13/21. Installation will be performed upon receipt of doors. Completion date: 11/30/21. Identify other potential deficient practice: All other doors on the SNF unit were inspected and met the Life Safety Code fire-rating. As Fire Doors is a construction item, not a	

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K 321	Continued From page 2 linen transport cart half full of soiled linens and one 5-gallon red biohazard trash container. The rating door tag revealed the door was a 20-minute door. The door was lacking a fire rated door of at least 3/4 hour. Observation of the fourth-floor medical records storage area near bedroom 410 on 08/16/21 at 11:45 AM revealed storage of 33 reams of paper files and two 5 ft. high by 2 ft. wide file cabinets full of paper storage. The rating door tag revealed the door was a 20-minute door. The door was lacking a fire rated door of at least 3/4 hour. Interview with the ESD at the time of the above observations verified the door rating tag read 20-minutes. The code requires hazardous area enclosures shall resist fire for at least 3/4 hour in accordance with NFPA 101 (2012 edition) section 8.7.1.1.	K 321	practice, once the doors have been installed, there will not be a re-occurrence of this deficient practice. Any door that needs to be replaced, will be 3/4 hour rated or higher.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	K 341		9/30/21

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K 341	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interview with the Administrator and Director of Environmental Services, the facility failed to ensure a fire alarm annunciator was installed on one of the two certified floors (4th Floor) in accordance with NFPA 72, 10.16.1, 10.16.1.1.1, 10.16.2.1, 10.16.2.1.1, 10.16.6 and 10.16.6.2. This deficient practice had the potential to affect all 19 residents on the fourth floor. Findings include: Observations on 08/17/21 at 11:25 AM revealed the fourth floor lacked an alarm annunciator that would alert staff of a fire location through the fire alarm system. Interview with the Director of Environmental Services and Administrator at the time of the observation verified that the fourth floor was lacking a fire alarm annunciator. Review of the facility fire plan titled, "Fire Safety Procedure," (no date) revealed, "5th floor RN uses walkie talkie to inform staff of the location of the fire." The code requires under NFPA 72 (2010 edition) the following: 10.16.1 "where required by governing laws, codes or standards, the location of an operating initiating device shall be annunciated by visual	K 341	K341 Johnson Control was contacted and came to the facility on 8/16/21. The quote for fire alarm annunciator was received on 9/14/21. Corrective Action: Alarm annunciator was ordered on 9/16/21. Due to the COVID pandemic, and shipping delays from the U.S. Mainland, delivery is expected by 11/16/21. Once the alarm annunciator is received, vendor will install. Completion date: 11/30/21. Systemic Changes: As fire annunciator is a construction item, not a practice, once the annunciator has been installed, there will not be a re-occurrence of this deficient practice. Staff are trained on the response to a fire alarm once it annunciates. Monthly fire drills are conducted and are reported to the Safety Committee. Any deficiency is reported to the Quarterly Quality Improvement Committee. The next meeting is scheduled for 10/22/21.	

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K 341	Continued From page 4 means." 10.16.1.1.1 "Visible annunciation of location of an operating device shall be by an indicator lamb, alphanumeric display, printout or other approved means." 10.16.2.1. "Trouble conditions shall be annunciated by visual means." 10.16.2.1.1. "Visual annunciation shall be by an indicator lamp, an alphanumeric display, a printout or other means." 10.16.6. "For the purpose of alarm annunciation, if a floor of a building is subdivided into multiple zones by firer or smoke barriers and the fire plan for the protective premises allow relocation of the occupants from the zone, each zone of the floor shall be annunciated separately."	K 341		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 NEW Buildings are to be 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 and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area	K 351		9/30/21

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K 351	Continued From page 5 of the closet does not exceed six square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure it maintained complete sprinkler coverage throughout the building in accordance with NFPA 13 (2010 edition) section 8.1.1. Lack of sprinkler coverage could allow the spread of smoke and fire throughout the building without containment. This deficient practice had the potential to affect all 42 residents who resided in the facility. Findings include: Observation of the dumb waiter on 08/16/21 at 11:20 AM revealed the chute opened on each floor and lacked sprinkler coverage. During an interview at the time of the observation, the Environmental Services Director (ESD) stated the dumb waiter is used for both floors of the nursing facility and contains an electric motor that propels it up and down the chute. The ESD confirmed the dumb waiter lacked sprinkler coverage. The code requires under NFPA 13 (2010 edition) section 8.1.1. that sprinkler coverage shall be installed throughout premises.	K 351	K351 Deficient Practice: There is only (1) dumb waiter in the facility. Johnson Control was contacted and came to the facility on 8/16/21 the facility received a quote for sprinkler for the trash chute on 9/17/21. Corrective Action: The fire sprinkler for the dumb waiter chute was ordered on 9/17/21. Equipment was received 9/22/21. Johnson Control will install 9/29, 9/30 & 10/1. Completion date: 10/1/21. Identify other deficient practice: As fire sprinkler is a construction item, not a practice, once the fire sprinkler has been installed, there will not be a re-occurrence of this deficient practice. The sprinkler system is inspected annually. The results of the inspection will be reported to the Quarterly Quality Improvement Committee. The next meeting is scheduled for 10/22/21.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 374		9/14/21

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K 374	Continued From page 6 Subdivision of Building Spaces - Smoke Barrier Doors 2012 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1-3/4 inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview with the facility Administrator, the facility failed to ensure that two of four sets of cross corridor smoke barrier doors closed properly in accordance with NFPA 101 (2012 edition) sections 18.3.7.8 and 18.2.2.2.7. This deficient practice had the potential to affect 21 of the residents in the facility. Findings include: Observation of cross corridor smoke barrier doors on 08/16/21 at 11:00 AM near bedroom 506 revealed when the doors were closed by the surveyor, one of the two smoke barrier doors was stuck on the carpeted floor and did not close completely. One door remained ajar two inches each time an attempt was made to close the door. Smoke barrier doors must close completely to prevent the passage of smoke and fire.	K 374	K374 Servdor was contacted and came to the facility on 8/16/21. Corrective action: the door closures were adjusted on 8/16/21 and again on 9/14/21. The door closures for near rooms 506 and 407 were tested and are closing properly. Completion date: 9/14/21. Identify other deficient practices: Facility inspected all other fire doors for appropriate closure and were found to be in compliance, except for the two noted above. Monthly inspections will be conducted by the Director of Facilities and/or designee, as part of the facility□'s monthly fire drills.	

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	125066	A. BUILDING **01 - KALAKAUA GARDENS** B. WING _____	**08/16/2021**

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K 374	Continued From page 7 Observations cross corridor smoke barrier doors on 08/16/21 at 11:30 AM near bedroom 407 revealed when the doors were closed by the surveyor, one of the two smoke barrier doors was stuck on the carpeted floor and did not close completely. One door remained ajar two inches each time an attempt was made to close the door. Smoke barrier doors must close completely to prevent the passage of smoke and fire. Interview with the Administrator at the time of the above observations confirmed the smoke barrier doors did not close as required. The code under NFPA 101 (2012 edition) section 18.3.7.8 requires, "doors in smoker barriers shall comply with 8.5.4. and the following. The doors shall be self closing or automatic closing in accordance with 18.2.2.2.7." Review of 18.2.2.2.7 revealed "any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure shall be permitted to be held open only by an automatic release device."	K 374	A QAPI has been developed to monitor this deficient practice. Results of the monthly inspections will be reported to the Quarterly Quality Improvement Committee. The next meeting is scheduled for October 22, 2021	
K 379 SS=E	Smoke Barrier Door Glazing CFR(s): NFPA 101 Smoke Barrier Door Glazing 2012 NEW Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9 This REQUIREMENT is not met as evidenced by:	K 379		9/30/21

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K 379	Continued From page 8 Based on observation and interview with the facility Administrator, the facility failed to ensure that two sets of cross corridor smoke barrier doors had vision panels in accordance with NFPA 101 (2012 edition) section 18.3.7.9. This had the potential to affect the 23 residents on the fifth floor. Findings include: Observation of two cross corridor smoke barrier doors on 08/16/21 at 11:00 AM by bedroom 506 and at 11:10 AM by bedroom 513 revealed both sets of doors were lacking vision panels. Interview with the Administrator at the time of the observations confirmed the cross corridor doors on the fifth floor lacked vision panels. The code requires under NFPA 101 (2012 edition) section 18.3.7.9. that "vision panels consisting of fire glazed frames shall be provided in each cross corridor swinging doors and at each cross corridor sliding door in a smoke barrier."	K 379	K379 Servdor was contacted on 8/19/21 the proposal for vision panels for the smoke barrier doors by room 506 and 513 was received on 9/13/21. Corrective action: Vision panels for the smoke barrier doors by room 506 and 513 were ordered on 9/13/21. Due to the COVID pandemic and shipping delays from the U.S. Mainland, expected delivery by 11/13/21. Installation will be performed upon receipt of doors. Completion date: 11/30/21. Identify other deficient practices: The facility inspected every smoke barrier door on the SNF unit and all other smoke doors met the Life Safety Code. As vision panels on smoke doors is a construction item, not a practice, once the vision panels have been installed, there will not be a re-occurrence of this deficient practice.	
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	K 918		9/17/21

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K 918	Continued From page 9 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 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, fire safety record review, and interview with the Director of Environmental Services (DES), the facility failed to ensure the emergency generator room had emergency lighting, failed to complete a recent load bank test, and failed to complete monthly load tests. The had the potential to affect all 42 residents in the facility. NFPA 110 (2010 edition) section 7.3.2, NFPA 99 (2012 edition) section 6.4.4.1.1.4 (a)(b), and NFPA 110 (2010 edition) section 7-13.4.3	K 918	K918 Cummins was notified and came to the facility on 8/16/21 and the proposal for the load bank test and monthly load test was received on 8/18/21. Corrective action: Cummins conducted the 36-month load bank test, as well as the monthly load test on 8/30/21. Systemic changes: The monthly load test	

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K 918	Continued From page 10 Findings include: Observation of the generator room on 08/16/21 at 11:45 AM revealed the room did not have battery powered emergency lighting available to illuminate the room in the event of power failure and generator failure. Interview with the DES at the time of the observation confirmed the room did not have battery powered emergency lighting. The code under NFPA 110 (2010 edition) requires, "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." Review of the facility generator contractor documentation located in the fire safety binder dated 04/07/21 revealed the report was completed for maintenance purposes. The documentation failed to include a load bank test or any other generator document. Further review of the fire safety binder revealed no written evidence of a load bank test. Interview with the DES on 08/16/21 at 3:15 PM confirmed there is no written evidence of a load bank test. The code under NFPA 110 (2010 edition) section 7-13.4.3. requires, "a load bank 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	K 918	is scheduled for the first Wednesday of every month at 5:00 am, for 30 minutes. Two battery operated emergency lights for the generator room were ordered and delivered on 9/10/21. They were installed on 9/16/21. The batteries will be checked monthly. Completion date: 9/10/21. The Director of Facilities and/or designee will audit the ensure that the monthly load test is being conducted for 30 minutes, one time per month, and that the batteries for the emergency lights have been checked and replaced if necessary. They will also monitor the 36-month minimum 2-hour load bank test for completion. The written results of the audit will be reported at the Quarterly Quality Improvement Committee Meeting. The next meeting is scheduled for 10/22/21.	

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K 918	Continued From page 11 the nameplate KW rating of the EPS." Review of facility generator testing records located in the facility fire safety binder revealed the facility lacked monthly load test documentation. Interview with the DES 08/16/21 at 3:15 PM confirmed there is no documentation of monthly load tests completed in the past 12 months. The code under NFPA 99 (2012 edition) 6.4.4.1.1.4 (A) and (B) requires, "(A) ... generator sets shall be tested 12 times per year at intervals of not less than 20 days and not more than 40 days apart ... (B)The scheduled test under load conditions shall include a complete and simulated cold start and appropriate automatic and manual transfer of all essential electrical and system loads."	K 918		

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E 000	Initial Comments A Life Safety Code (LSC) Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Department of Health, Office of Health Care Assurance on 08/16/21. The facility was found not to be in compliance with 42 CFR 483.73.	E 000		

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

Electronically Signed | 09/18/2021

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