STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	125046		05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on May 17, 2021. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Three complaint's were investigated in Aspen complaint tracking system (ACTS) #8134, #8746, #8589 and were not substantiated. One facility reported incident (FRI) #8824 was substantiated and cited. The highest scope and severity (S/S) = G for F689 Free of Accident Hazards/Supervision/Devices. Survey dates: May 12, 2021 to May 17, 2021. Survey Census: 69. Sample size: 17.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		6/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2021

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to protect and promote quality of life for Resident (R)2 by making sure that he was treated with respect and dignity. Specifically, the facility failed to ensure that English was consistently spoken in all resident care areas, exposing R2 to embarrassing situations. This deficient practice has the potential to affect all residents in the facility. Findings Include: On 05/12/21 at 01:33 PM, during an interview with R2 in his room on Unit 1, R2 complained that sometimes staff talk to each other in Filipino and	F 550	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1. R2□s regularly assigned care givers were inserviced regarding respecting resident□s dignity by only speaking English in the resident□s presence. 2. Facility residents have the potential to	

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F 550	Continued From page 2 laugh when they are cleaning and changing him. R2 stated that he finds this very upsetting and has asked them to stop, but it continues. R2 said he has also complained about this behavior to management but has seen no improvement. On 05/17/21 at 08:11 AM, several signs were observed throughout the facility, such as at the nursing stations, and on office doors, reminding staff to speak English. On 05/17/21 at 09:56 AM, during an interview with the Resident Care Manager (RCM)1 in her office, RCM1 stated that signs reminding staff to speak English in resident care areas have been posted in all common areas of the facility for a while. In addition, RCM1 said that the topic of speaking English was not a new or recent issue, and that it was covered at meetings regularly. RCM stated that she had just discussed it again at a staff meeting.	F 550	be affected by the alleged practice. 3. Facility staff were reinserviced regarding speaking English only in the presence of the residents and in the facility by the SDC /designee. Inservices will be ongoing as needed. 4. DON / SDC / Unit managers / designee will audit for compliance through observations and random interviews with residents on rounds 3x weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the	F 583		6/28/21

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F 583	Continued From page 3 right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to respect the right to personal privacy for one resident (R)2. Specifically, the facility failed to provide privacy for R2 when using the bathroom for personal care, failed to accommodate his requests for privacy, and failed to protect his privacy of oral communications. As a result of these deficient practices, R2 was placed at risk for a decreased quality of life. This deficient practice has the potential to affect all residents in adjoining rooms without bathroom doors. Findings Include: On 05/12/21 at 01:36 PM, an observation and concurrent interview was done with R2 in his room on Unit 1. R2 was housed in a room that	F 583	1. Bathroom doors were installed in R2□s room. Doors were installed between room 23 and 24. 2. Facility residents have the potential to be affected by the alleged practice. 3. Facility staff were reinserviced regarding privacy by the SDC /designee. Inservices will be ongoing as needed. 4. Adm / DON / SW / designee will monitor for compliance with privacy matters through observations and random interviews with residents on rounds 3x weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	

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F 583	Continued From page 4 shared a bathroom containing a toilet and a shower, with the room next to it. The bathroom was located between the two rooms, with a fabric curtain hanging from the top of the doorway separating each room from the bathroom. R2 had his television (TV) on with the sound muted. The TV of a resident in the adjoining room could be heard clearly and loudly from R2's bed, making it difficult for him to hear my questions. R2 stated "that" is the reason why he leaves his TV on mute, "because no use" competing with the volume of the TV in the next room. R2 complained about not having a door between his room and the bathroom stating, "there's no privacy, can hear and smell everything going on in the bathroom, can see through the slits in the curtain straight into the other room." R2 also said that he cannot have a private conversation on the phone because everything can be heard in the next room. R2 stated that he had spoken to staff about the lack of privacy, and had asked for doors, but had received no response. On 05/13/21 at 01:45 PM, during a tour of Unit 1, it was observed that Rooms 23 and 24 also shared a bathroom with no doors in between. On 05/13/21 at 01:53 PM, an interview was done with the Director of Nursing (DON) in the Unit 1 Dining Room. When questioned about the privacy issue in rooms without bathroom doors, the DON acknowledged that he was aware of R2's complaints and requests but that maintenance was having trouble finding doors that would fit. On 05/17/21 at 09:39 AM, during an interview and tour of Unit 1 with the Resident Care Manager (RCM)1, RCM1 stated that R2's room now had a bathroom door. Pointed out to RCM1 that Rooms	F 583		

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F 583	Continued From page 5 23 and 24 were also lacking bathroom doors. Asked RCM1 if residents were assessed for preferences or specific medical issues prior to being placed in these rooms. RCM1 responded "no", stating that they simply tried to ensure that if male residents were in one room, only male residents would be placed in the adjoining room, and vice versa for female residents.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each	F 584		6/28/21

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F 584	Continued From page 6 resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe, clean environment, free of odors and safety hazards for the residents and staff at the facility, as evidenced by an odorous storage room for shower chairs, an odorous and dimly lit bathroom shared by eight residents, and two tile shower stalls with either no non-slip safety strips, or worn-out safety strips on the floor. As a result of this deficient practice, the staff and residents were placed at risk for avoidable injuries and a decreased quality of life. This deficient practice has the potential to affect all the residents and staff at the facility. Findings Include: 1) On 05/12/21 at 08:51 AM, while doing a tour of Unit 1, the storage room across from Room 8 was noted to be full of shower chairs with a strong odor emanating into the hallway when the door was opened. On 05/12/21 at 09:09 AM, an interview was done with the Infection Preventionist (IP) outside of the Unit 1 storage room across from Room 8. The IP	F 584	1. The storage room and shower room were thoroughly cleaned and sanitized by the housekeeping team. Both shower stalls had safety strips installed by the Maintenance team. 2. Facility residents have the potential to be affected by this alleged practice. 3. Facility staff were reinserviced regarding a safe, clean environment by the SDC /designee. Inservices will be ongoing as needed. 4. Adm / Maintenance Director / Housekeeping Supervisor / designee will monitor for compliance with safe, clean environment through observations on rounds 3x weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	

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F 584	Continued From page 7 stated that the shower chairs in the room were actively used by the nurse aides (NA) to bathe residents, then washed down with water and "disinfected with purple wipes" before being placed back in the room. When the IP was asked to identify the odor coming from the room, the IP answered, "something soiled ...[with] urine." Upon inspection of the room and the shower chairs in it, no dried soil or fluid was visible. The IP stated the odor might be coming from the room itself and acknowledged that something needed to be done about the odor. On 05/17/21 at 09:37 AM, during an interview and tour of Unit 1 with the Resident Care Manager (RCM)1, she acknowledged the odor coming from the storage room containing the shower chairs and said she would check with housekeeping if something could be done about the odor. 2) On 05/12/21 at 09:31 AM, an observation and concurrent interview was done with Resident (R)50 in her room on Unit 1. R50 complained that the all-tile floor in the bathroom (shared by the four residents in rooms 8 and 9) was very slippery when wet, especially after showering when there was soap residue on her feet or the shower floor. Then, stepping from the wet tile to the wooden floor of her room was also slippery, so much so that the NAs would place a sheet on the floor from the bathroom to her bed so she would not slip. Upon observation, it was noted that the bathroom floor was continuous tile from the toilet to the shower stall, with no physical barrier or separation. The shower floor did not have a bathmat or any of the non-slip safety strips noted in the other resident bathrooms on the unit. R50 stated that she had fallen in the	F 584		

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F 584	Continued From page 8 bathroom a couple months earlier, but said the floor was not wet at the time. 3) On 05/12/21 at 10:38 AM, an observation was done in the bathroom shared by the eight residents in rooms 2 and 3. This bathroom also had a continuous tile floor running from the toilet to the shower stall with no barrier or separation. The non-slip safety strips applied to the shower floor were noted to be worn smooth. The toilet had a strong odor that could be smelled from outside the bathroom, and the lighting in the bathroom (where the toilet and shower were located) was significantly darker than the lighting at the sink outside the bathroom. On 05/17/21 at 09:42 AM, during an interview and tour of Unit 1 with RCM1, when arriving to the bathroom of Rooms 2 and 3, she acknowledged the lighting in the bathroom was dim, that there was an odor in the bathroom, though she described it as "smells like old building," and agreed that the non-slip safety strips in the shower were worn smooth. RCM1 confirmed that all eight residents in the two rooms were bathed regularly in that shower stall, with most of them requiring extensive assistance. On 05/17/21 at 11:41 AM, an interview was done with the Maintenance Director (MAIN) in the conference room. MAIN explained that renovations were currently underway on Units 1 and 2. Regarding the bathroom floors, MAIN stated that the facility had contracted with an outside vendor to apply an epoxy finish to the floors "right before COVID hit." The vendor was still contracted to do the work but had been waiting for over a year to be allowed into the facility. MAIN said the epoxy finish was supposed	F 584		

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F 584	Continued From page 9 to provide a new surface to the tile floors, making them cleaner, brighter, and "I believe less slippery." When asked about the non-slip safety strips in the showers, MAIN stated that the facility used to replace them regularly but had been waiting for the epoxy finish to be applied to put new strips on. MAIN acknowledged that the resident's safety might have been compromised in the meantime and that he would have maintenance staff check for strips that needed to be installed or replaced. Regarding the poor lighting in the bathroom of rooms 3 and 4, MAIN stated no one had notified maintenance of that yet, and that he would have his staff check it out.	F 584		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 604		6/28/21

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F 604	Continued From page 10 §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview with staff members, the facility failed to provide ongoing monitoring for the continued use of a physical restraint to ensure the physical restraint is not used for staff convenience for Resident (R) 54. Findings Include: R54 was admitted to the facility on 02/27/20. Diagnosis include traumatic subdural hemorrhage without loss of consciousness, unspecified encephalopathy, unspecified dysphagia, unspecified dementia with behavioral disturbances, unspecified anxiety disorder, and other speech and language deficits following non traumatic subarachnoid hemorrhage. On 05/13/21 at 01:50 PM, observed R54 in his room with multiple attempts to stand up from his wheelchair with his seatbelt on. Certified Nursing Assistant (CNA) 48 and CNA56 entered R54's room and concurrently observed R54 attempt to stand up. CNA56 asked R54 if he is tired and if he wanted to go to bed. Surveyor inquired why R54 is wearing a seatbelt, CNA56 stated R54 wears a seatbelt because he keeps standing up. Surveyor observed the seat belt was taken off	F 604	1. R54 was reassessed for usage of a seatbelt. His/her orders, consents, care plan was updated as needed. (There is no resident 48 identified on the resident roster nor is there a second resident with a seatbelt) 2. Facility residents using restraints have the potential to be affected by the alleged practice. 3. Direct care staff were reinserviced regarding restraint usage and care planning by the SDC /designee. Inservices will be ongoing as needed. 4. DON / SDC / Unit managers /designee will monitor for compliance with restraint usage through observations on rounds and medical record reviews weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	

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F 604	Continued From page 11 when he ate lunch and after lunch it was put back on. Review of physician's order prescribed on 06/17/21, "Okay for wheelchair seat belt PRN (as needed) for restlessness." On 05/14/21 at 10:13 AM observed R48 sitting in his wheelchair with his seatbelt on, no attempt to stand up from his chair or restlessness. Surveyor Interviewed Registered Nurse (RN) 19 on 05/17/21 at 11:00 AM, stated when R54 is restless the CNA(s) will inform her, and she will initiate the seatbelt restraint PRN. After the restraint is initiated, RN19 stated nursing staff monitor and remove the restraint every two hours. Inquired where is the monitoring and restraint release logged? RN19 stated she does not document the monitoring and does not know where to find the log. Interview with Resident Care Manager (RCM) 2 on 05/17/21 at 11:03 AM, stated she does not know where nursing staff log the monitoring of restraints and need to ask and get back to surveyor. Interview with Director of Nursing (DON) on 05/17/21 at 11:05 AM, stated nursing staff are to monitor residents with restraints and release the restraint every two hours. Inquired if there is a monitoring log for restraints, DON stated he will need to ask the RCM because they implement it with nursing staff and do the training. Review of the CNA Job Description under Safety and Sanitation, "For residents who have restraint orders, retrain as instructed in chair/bed. Check	F 604		

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F 604	Continued From page 12 restrained residents at least every 30 minutes. Release restraints at least every 2 hours and maintain record of times and duration restraints were released." Concurrent review of R54's Treatment Administration Record (TAR) with DON on 05/17/21 at 12:01 PM, on 05/13/21 at 10:55 AM the wheelchair seatbelt was initiated due to restlessness and was found effective at 12:04 PM. On 05/14/21 at 11:23 AM the wheelchair seatbelt was initiated due to restlessness and was found effective at 03:55 PM and noted at 10:47 PM effective "off at 20:00." Inquired whether "Effective" means the seat belt restraint was released, DON stated he did not know the answer and the record only shows when the restraint was given but not when it is taken off. DON further stated there is no other form used to document the monitoring of the restraint. The facility failed to review and revise R54's care plan to include the wheelchair seat belt as a physical restraint (refer F567).	F 604		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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	F 657		6/28/21

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F 657	Continued From page 13 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 record review and interview with staff members, the facility failed to review and revise Resident (R) 54's care plan to include the wheelchair seat belt as a physical restraint. Findings Include: R54 was admitted to the facility on 02/27/2020. Diagnosis includes traumatic subdural hemorrhage without loss of consciousness, unspecified encephalopathy, unspecified dysphagia, unspecified dementia with behavioral disturbances, unspecified anxiety disorder, other speech and language deficits following non traumatic subarachnoid hemorrhage, unsteadiness on feet, and muscle weakness (generalized). Interview with Certified Nursing Assistant (CNA) 56 on 05/13/21 at 01:50 PM, stated R54 wears a seatbelt in his wheelchair because he keeps	F 657	1. R54 was reassessed for usage of a seatbelt. His/her orders, consents, care plan was updated as needed. 2. Facility residents using restraints have the potential to be affected by the alleged practice. 3. Direct care staff were reinserviced regarding restraint usage and care planning by the SDC /designee. Inservices will be ongoing as needed. 4. DON / SDC / Unit managers /designee will monitor for compliance with restraint usage through observations on rounds and medical record reviews weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	

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F 657	Continued From page 14 standing up, the seat belt was taken off when he ate lunch and after lunch it was put back on. CNA56 further stated she believes the seatbelt restraint is in R54's care plan. Concurrent review of R54's care plan last revised on 04/27/21 with Director of Nursing (DON) on 05/17/21 at 01:12 PM, the care plan does not include the use of the wheelchair seatbelt as a physical restraint. Although the care plan addresses the prevention of falls by assessing " ...for use of WC (wheelchair) seat belt when restless," the care plan does not define and implement interventions during the use of the restraint, provide ongoing monitoring for the continued use, including the length of time the restraint is anticipated, who may apply the restraint, where and how the restraint is to be applied and used, and the time and frequency the restraint should be released. The care plan also does not address direct monitoring and supervision, including documentation of the monitoring. The facility failed to provide ongoing monitoring and ensure a physical restraint is not used for staff convenience for R54 (refer F604).	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		6/28/21

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F 689	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interviews, record review, Policy and procedure, the facility failed to provide a safe environment for Resident (R) 174 which resulted in a fall with injury. R174 required hospitalization and surgery for her injury. Findings include: R 174 sustained a fall with injury while left unattended in the restroom during a shower. R174 has a history of cerebral infarction, hemiplegia affecting left nondominant side. dysarthria. She has generalized muscle weakness and is unsteady on her feet. Record review of a facility reported event report on 05/12/21 revealed that R174 requested to use a shower chair that was too small for her size, and insisted to the certified nursing assistant (CNA)1 to place 3 blankets on the chair to make her sit higher on the shower chair. CNA1 told R174 that this would be unsafe for her. CNA avoided more discussion because R174 would get upset with her. Although CNA1 did state that it was an unsafe shower chair, CNA1 did not get help from the assigned Registered Nurse (RN)17 who was the charge RN. Furthermore, the event report stated that CNA1 left the resident unattended during the shower three times, 1) while R39 was brushing her teeth, 2) CNA1 left to attend to R174's roommate and 3) to start to put away R174's shower belongings. At approximately 2015 on 04/24/21. CNA1 heard R174 yelling for help. Interview on 04/13/21 with RN17, stated that the night of the incident that R174 fell, CNA1 did not come and discuss the unsafe matter with her.	F 689	1. R174 is being showered in an appropriate chair for her size. R174 was inserviced by the DON on not using blankets/ towels/ etc. to sit on while in the shower chair and using unsafe equipment or procedures. Resident□s care plan was updated to reflect the use of an appropriate shower chair rated for her weight / size and not using any towels or blankets, etc to sit on. If resident wishes to use alternative methods to bathe, it was agreed upon with resident and DON that she will discuss with the DON prior to her wanting to try the method to make sure it was safe for her. CNA 1 was re-inserviced regarding safety during showering, following the care plan and reporting of safety concerns to the DON. 2. Facility residents requiring showering have the potential to be affected by this alleged practice. 3. Direct care staff were reinserviced regarding appropriate showering techniques and reporting concerns to supervisors by the SDC /designee. Inservices will be ongoing as needed. 4. DON / SDC / Unit managers /designee will monitor for compliance with showering techniques through observations on rounds 3 x weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	

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F 689	Continued From page 16 She further stated that if the CNA1 had come to discuss this matter, she would not have allowed it. RN 17 showed me the shower chair that R174 sat on. R174 is reported to be approximately 205lbs and the shower chair was a small version, not the right size for someone of that weight. It was also noted by R 17 that there were three blankets placed on the shower chair at the time of the incident. This action propped the resident higher in the chair, making R174, at 205lbs, top heavy. This measure placed the resident at an unsafe risk for a fall. Record review of the job description for a certified nurse's aide, under safety and sanitation, (#14) Report all hazardous conditions and equipment to the charge nurse immediately. Record review of the job description of the Registered Nurse (RN) under essential functions, #12 states Communicates specifics of care for each resident to the C.N.A. Overseas care delivery by CNAs. Assists C.N.A.s as necessary. Record review of a competency checklist for CNA1 on giving a shower, (#14) states stay with the resident during the procedure for resident's safety. R174 sustained an unattended fall in the shower on 04/24/21 when she was left alone. In addition, R174 had insisted that she be placed in a shower chair that was "too small" for her and to add three blankets to be placed on the chair. This request placed R174 in an unsafe position in that the resident sat high above the armrests and had an unwitnessed fall. This deficient practice had the potential to affect the other residents identified in the facility	F 689		

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F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review (RR), the facility failed to ensure there was enough staff to provide services and respond to each resident's needs in a timely manner, as evidenced by long call light wait times, complaints of cold food, and no staff at the Nurse's Station to answer the phone. As a result of this deficient practice, the residents experienced a decreased	F 725	1. RD, RN 19, and unit manager were reinserviced on answering call lights by the SDC. Inservices will be ongoing as needed. Meal temperatures were monitored throughout the meal at time of survey and temperatures were within compliance. Hot food was at appropriate hot temperatures and cold food was at	6/28/21

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F 725	Continued From page 18 quality of life and were unable to attain their highest practicable well-being. Findings Include: 1) On 05/12/21 at 09:31 AM, an interview was done with Resident (R)50 in her room on Unit 1. R50 stated "the facility is understaffed," and explained that she has had to wait half an hour for the call light to be answered sometimes. As a result of having to wait, R50 said she has had to sit on the toilet or bedside commode for long periods, experiencing lower back pain from being in the same position for too long, she has had difficulty breathing while waiting for staff to come in to adjust her oxygen regulator, and she has had a bowel movement while in bed because she could not hold it any longer. Although she was wearing an incontinence brief at the time, R50 said she does not like to use it because she hates the feeling of sitting in a soiled brief. "[The] CNAs [certified nurse aides] are always busy with other residents, they gotta tube feed, gotta bathe residents, help residents to the bathroom, for meals they have to go to [the] kitchen and pick up [meal] trays and bring to the rooms." As a result, R50 said she is "told to wait a lot of times" when she calls for help, and sometimes gets her food cold. In addition to not providing timely resident care, R50 complained that there is never any staff at the Nurse's Station to answer the phone, explaining that her sister had recently tried calling for three days to arrange drop-off of items for R50's birthday, but no one answered the phone. R50 stated she has discussed the insufficient staffing with the Minimum Data Set Coordinator (MDS), the Resident Care Manager (RCM)1, and the Director of Nursing (DON), and was told that "no one is applying."	F 725	appropriate cold temperatures. Temperatures are taken with all meals and are appropriate. 2. Facility residents have the potential to be affected by the alleged practice. 3. Facility staff were reinserviced regarding answering call lights and phones by the SDC / Unit managers / designee. Inservices will be ongoing as needed. Dietary manager / DON / designee re-inserviced dietary staff and cnas regarding meal tray pass. Inservices will be ongoing as needed. 4. DON / SDC / Unit managers / Dietary manager / designee will monitor for compliance through call light observations on rounds and meal tray pass, auditing of food temperatures and resident interviews 3 x weekly for a minimum of 12 weeks or until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	

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F 725	Continued From page 19 2) On 05/12/21 at 10:55 AM, an interview was done with Resident (R)51 in his room on Unit 1. When asked about staffing, R51 stated that, "sometimes gotta wait long, sometimes [they] bring [the] food late." R51 explained that he has had to wait for half an hour sometimes before staff responds to his call light. As a result of insufficient staffing, R51 said that sometimes he gets his food cold, and he does not get to shower when he would like to but must wait for when staff has the time. 3) On 05/12/21 at 12:11 PM, during a dining observation in the Unit 1 Dining Room, it was noted that the CNAs were lined up at the kitchen pass-thru window waiting for lunch trays to be placed on the counter. As kitchen staff made each tray, they would place it on the counter where a CNA would cover the entire tray with cling wrap and deliver it to the appropriate resident one-by-one. There were no plate covers, or cup covers observed on the meal trays, only the cling wrap applied by the CNA. CNA73 was followed to Room 8 with a meal tray, and she was observed placing the meal tray on the resident's bedside table, washing her hands and wetting a washcloth at the sink, assisting the resident to wash their hands with the washcloth, then unwrapping their meal tray and setting it up for them. CNA73 was then followed back to the dining room where she washed her hands again and waited for the next meal tray to deliver. This process of hand-carrying each meal tray one-by-one, from the kitchen to the resident's room, continued until meal service was done. It was noted that there was no kitchen staff available to cover the meal trays or expedite delivery in any way, and there were no tray carts	F 725		

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F 725	Continued From page 20 used for transport. 4) On 05/12/21 at 01:24 PM, an interview was done with R2 in his room on Unit 1. R2 stated, "they're real shorthanded here, especially if you on this end [of the unit]." R2 explained that sometimes he has had to wait for forty-five minutes for staff to respond to his call for help. R2 said it is very frustrating that there is not enough staff to help, stating that sometimes he receives his meals cold, and if he did not ask for help to brush his teeth or wash his hands each morning, it would not get done. R2 also complained that there is never anyone at the Nurse's Station to answer the phone, stating that every time his brother or his nephews "call the front [Nurse's Station], nobody pick up." 5) On 05/12/21 at 04:00 PM, during a phone interview with R56's family representative (FR), FR expressed her concerns about sufficient staffing. FR stated, "every time I've called, no one picks up the phone." R56 is completely dependent on staff for all his needs, so FR likes to call the facility for updates on R56's condition frequently. FR said that she knows the facility is short-handed, and she worries that R56 is not getting the care he would be getting if she could visit him inside again. FR explained that before COVID she used to visit R56 weekly, and every week she had to brush his teeth due to a visible buildup of plaque. She has asked repeatedly for staff to be sure to brush R56's teeth daily but is doubtful that this is happening. 6) On 05/14/21 at 09:47 AM in Unit 2, observed the call light on outside of room 29 for resident (R) 62. Observed Registered Nurse (RN) 19 at the medicine cart near the Nurse's station on the other side of the hallway from room 29.	F 725		

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F 725	Continued From page 21 Registered Dietician (RD) entered Unit 2 hallway and stopped to introduce herself to surveyor. RD proceeded to walk past R62's room without acknowledging R62's call light. At 09:51 AM observed Social Services Director (SSD) enter R62's room and ask him if there is anything he needs, R62 replied and stated he needs to use the bathroom. SSD then informed R62 she will look for a Certified Nursing Assistant (CNA) and exited R62's room. At 09:52 AM observed Resident Care Manager (RCM) 2 enter R62's room and turn off the call light. Observed R62 and RCM2 talking before RCM2 exited the room. At 09:54 AM observed SSD enter R62's room and inform him " ...they are hunting for a CNA ..." and exited the room. At 09:55 AM observed the call light for R62 go back on. At 09:56 AM observed CNA39 answer R62's call light and proceed to provide R62 care. Interview with CNA39 on 05/14/21 at 10:10 AM, CNA39 stated she is assigned to R62 but was busy helping a resident with another CNA. Inquired what R62 was requesting, CNA39 explained that R62 needed to use the bathroom and she helped him change his clothes, clean his bed pan, and gently wash him with a sponge. CNA39 further explained R62 always uses the bed pan for bowel movements and is never taken to the toilet because he needs two persons assist for the Hoyer Lift.	F 725		

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F 725	Continued From page 22 7) Interview on 05/17/21 11:05 AM with staffing person (SP) and Director of Nursing (DON) was done. The concern regarding call lights was brought up and the DON stated that they are in the process of getting a new call light system. DON pointed to the phone that was on his desk and stated that this was just put in and we are expecting a whole new system. The system will be able to track calls and actually prioritize what call to go to next. The certified nurse's aides would have phones and be able to see in what order the call came into. In the same interview, a query was done with SP and DON regarding acuity and staffing, DON stated, it is based on census. We also go two staff above the recommended. I have looked for an acuity grid for Hawaii but there is none. In the mainland, they go to 15"21 but Hawaii is a lot more generous than the mainland.	F 725		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review (RR), the facility failed to ensure a medication error rate of less than 5%, as evidenced by two medication errors observed out of thirty-five opportunities for errors, for an error rate of 5.7%. One of the two errors occurred twice a day for almost a month despite the pharmacy warning label. Safe medication	F 759	1. R49 medication was adjusted and resident suffered no ill effects. Physician notified of errors. LPN 2 was reinserviced regarding medication administration by the SDC. Inservices will be ongoing as needed. 2. Residents receiving medications via G-tube have the potential to be affected	6/28/21

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F 759	Continued From page 23 administration practices are essential for the health and well-being of the residents. As a result of this deficient practice, one resident (R)49 was placed at risk of a rectal bleed recurrence. This deficient practice has the potential to affect all residents in the facility. Findings Include: 1) R49 was a 68-year-old male admitted on 04/16/21 to Unit 1 for long term care. His diagnoses included: intracranial hemorrhage (bleeding within the skull), hemiplegia (paralysis) and hemiparesis (muscle weakness) of the right side, hemorrhage of anus and rectum (requiring blood transfusions on 03/30/21 and 04/06/21) due to anal and rectal ulcers, and he had a PEG tube (a flexible feeding tube inserted through the abdominal wall and into the stomach) for nutrition, medications, and fluids. On 05/14/21 at 07:55 AM, an observation and concurrent interview was done with Licensed Practical Nurse (LPN)2 as she prepared and administered medications to R49. Observed LPN2 crushing R49's medication tablets for administration through his PEG tube. As LPN2 prepared to crush R49's omeprazole DR (delayed release) 20mg tablet, the State Surveyor (SS) stopped her to point out the pharmacy label on the packaging stated, "Do Not Crush or Chew." LPN2 said she was unaware that the medication had that label, but that she had to crush it so she could give it through his PEG tube. LPN2 then crushed it to be mixed with water for administration. RR of the physician orders noted an order for omeprazole DR 20mg via gastric tube twice a	F 759	by the alleged practice 3. Licensed nursing staff were reinserviced regarding appropriate medication administration by the SDC / Unit managers / designee. Inservices will be ongoing as needed. 4. DON / SDC / Unit managers /designee will monitor for compliance through med pass observations rounds 3 x weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	

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	125046		05/17/2021

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 759	Continued From page 24 day. Further review of physician orders revealed an order from 04/16/21, "May crush medications if not pharmacologically contraindicated". No communication to the physician or pharmacy was found regarding crushing a delayed release tablet that the pharmacy had labeled, "Do Not Crush." RR of the Medications Administration History revealed the omeprazole had been documented as administered twice a day, beginning on the evening of 04/16/21. On 05/17/21 at 09:47 AM, an interview was done with the Resident Care Manager (RCM)1 in her office. RCM1 confirmed that everyone had been crushing the omeprazole despite the pharmacy warning label. Said that the pharmacy should have faxed or called the facility to clarify the route before sending the medication. Documentation of that communication was requested. RCM1 also stated that the evening shift nurse had been asked to clarify the omeprazole order with the physician. It was noted at this time that there was no medication error report initiated for the mistake. On 05/17/21 at 12:40 PM, another interview was done with RCM1 in her office. RCM1 stated she could find no clarification or communication regarding the omeprazole DR prior to the pharmacy sending the medication. Said that a new order was obtained today from the physician, changing the omeprazole to Zegrid, which can be crushed. 2) On 05/14/21 at 08:00 AM, an observation and concurrent interview was done with LPN2 as she continued preparation and administration of R49's medications. Observed LPN2 pour out 20mL of sucralfate 1gm/10ml suspension into a cup.	F 759		

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F 759	Continued From page 25 LPN2 was observed reading the label on the bottle and looking at the computer prior to pouring the medication. SS observed the medication label read "Give 20mL rectally." After administering his crushed medications via R49's PEG tube, followed by the appropriate amount of water to flush the tube, LPN2 was observed pouring the sucralfate into the PEG tube as well. When questioned why she administered the sucralfate through the PEG tube and not rectally as the medication label said, LPN2 double-checked the order in the computer and confirmed that the physician order said rectally. LPN2 expressed confusion, stating that she had always given the sucralfate through the PEG tube. RR of the Medications Administration History revealed that this was the fifth time since his admission that LPN2 had administered R49's sucralfate. Further review of the physician orders noted an order for sucralfate suspension 100mg/mL, "give 20mL rectally using a 14-French rubber catheter and syringe. Insert 2 inches and give over several seconds due to rectal ulcers." On 05/17/21 at 09:47 AM, an interview was done with RCM1 in her office. RCM1 stated that the physician had been notified that the sucralfate was given via PEG tube, and a medication error report had been initiated on 05/14/21. Said that the physician wanted to continue the medication rectally.	F 759		
F 761 SS=E	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	F 761		6/28/21

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F 761	Continued From page 26 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 record review, the facility failed to ensure all medications used in the facility were labeled in accordance with professional standards, including expiration dates and resident names. Proper labeling of medications is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility. Findings Include: On 05/14/21 at 05:15 AM, an inspection of the medication cart at the Unit 1 nurse's station was	F 761	1. Any expired medications were removed from medication carts and storage rooms. Any medications found without labels were removed, destroyed and replaced. LPN 3 was reinserviced regarding expired medication, appropriate storage and labeling of medications by the SDC. Inservices will be ongoing as needed. 2. Facility residents receiving medications have the potential to be affected by the alleged practice. 3. Licensed nursing staff were reinserviced regarding expired	

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F 761	Continued From page 27 done with Licensed Practical Nurse (LPN)3 present. The inspection revealed a glucagen hypokit with a manufacturer's expiration date of 10/2020, and a bottle of folic acid with a manufacturer's expiration date of 03/21. There were also three bottles of medication (vitamin C 500mg, acetaminophen 500mg, vitamin D 1000iu) that were labeled as having been opened over one year ago. In addition, there were nine other bottles of various over-the-counter (OTC) floor stock medications that either were not labeled with the date they had been opened, or were labeled with an incomplete date, such as "2/21". On 05/14/21 at 05:47 AM, an interview was done with LPN3 at the Unit 1 nurse's station. LPN stated she was unsure how long the OTC medications were good for after being opened. Reviewed what was found in the cart with LPN3 and she acknowledged that the expired items should have been pulled out earlier. LPN3 then removed the thirteen bottles and one hypokit from the cart. On 05/14/21 at 05:50 AM, an inspection of the medication cart outside of room 5 on Unit 1 was done with LPN3 present. The inspection found an Admelog SoloStar insulin pen labeled with a sticker of when it had been opened and when to discard it, however there was no pharmacy label indicating the resident's name, and no name had been written on it. Two bottles of OTC floor stock medications that either were not labeled with the date they had been opened, or were labeled with an incomplete date, such as "12/19," were also found. At 06:09 AM findings were reviewed with LPN3. LPN3 agreed that the insulin pen should be labeled with a resident's name and removed	F 761	medications, appropriate storage and labeling of medication administration by the SDC / Unit managers / designee. Expired or discontinued medications from carts will be placed in medication storage rooms for destruction or return to pharmacy daily as needed. Unit managers will destroy or return expired medications from the medication storage room weekly. Inservices will be ongoing as needed. 4. DON / SDC / Unit managers /designee will monitor for compliance through medication audits of carts and storage rooms 3 x weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	

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F 761	Continued From page 28 the insulin pen and the unlabeled/incompletely labeled items from the cart. On 05/14/21 at 06:12 AM, an inspection of the Unit 1 medication storage room was done. Immediately observed upon entering the room was a sign posted on the locked cabinet titled "House Stock Medications." The sign reminded staff to, "ALWAYS LABEL WITH DATE: MONTH/DAY/YEAR MEDICATION EXPIRES ONE YEAR FROM DATE OPENED (OR SOONER IF MANUFACTURER'S EXPIRATION IS PRIOR TO THAT)." A review of the facility's policy and procedure (P&P) for Medications and Medication Labels, taken from the Nursing Care Center Pharmacy Policy & Procedure Manual, copyrighted by PharMerica Corp in 2007, noted that "Each prescription medication will be labeled to include: a. Resident's name ...." Further review of the facility's P&P for House Supplied (Floor Stock) Medications, taken from the same PharMerica Corp source, noted the following: " ...unless otherwise specified, the expiration date is limited to the expiration date on the original container or one year's time from date of opening, whichever comes first."	F 761		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced	F 810		6/28/21

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F 810	Continued From page 29 by: Based on observation, interview and record review. The facility failed to provide one Resident with adaptive equipment (built up utensils and bowls) to help him eat independently. Although R16 was evaluated by Occupational Therapy (OT) and determined to benefit from the adaptive utensils and bowls, he was not using them and instead struggled with the task of eating. It was also determined that the adaptive utensils lowered his fall risk due to him leaning over to pick up the food he spilled on the floor. The deficient practice resulted in the inability of the resident to effectively eat food and snacks and increase his risk for falling. Findings include: Surveyor observed Resident (R)16 in the dining room during the lunch meal on 05/12/21 at 12:09 PM. Staff were passing lunch trays to the residents sitting in the dining room. Other trays were taken to the resident's who stayed in their room. R16, noted with right side weakness, and leaning to the right was sitting up in his wheelchair at a table. R16 tried to feed his self with a spoon. Each time R16 raised the spoon the food fell off before it would get to his mouth. At 12:30 PM R16 picked up and held his plate with his right hand and attempted to scoop the food into his mouth with his spoon. R16 continued to attempt to take bites of his food until 01:40 PM, when he fell asleep at the table. At no time was he assisted by staff to eat the lunch meal. Surveyor reviewed the electronic medical record on 05/14/21 at at 12:46 PM. The minimum data set (MDS) with review date of 03/07/21. R16	F 810	1. R16 was reassessed for assistive devices by therapy. Care plan was updated to reflect device usage. RN 24 was re-inserviced regarding the use of assistive devices with meals by the SDC. Inservices will be ongoing as needed. 2. Residents using assistive devices during meals have the potential to be affected by the alleged practice. 3. Direct care staff were re-inserviced regarding the use of assistive devices with meals by the SDC / designee. Inservices will be ongoing as needed. 4. DON / SDC / Unit managers /designee will monitor for compliance through med pass observations rounds 3 x weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	

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F 810	Continued From page 30 scored 1 for eating. "encourage and cue resident only" and scored 2 for set up assistance. Surveyor interviewed the OT on 05/14/21 at 12:50 PM in the conference room. When asked if R16 has a built up spoon or plate for eating, he replied that we gave him a dicing pad, a grip pad, scoop bowl, and built up spoon. We gave him a scoop bowl and plate guard. There's a tendency for him to lean over and fall out of the chair when he would drop food on the floor. The special utensils should be kept in the kitchen. The OT validated that if R16 uses the utensils it should decrease his fall risk. He was falling and that's why he was referred to us. Surveyor reviewed the monthly nursing summary dated 04/12/21 on 05/14/21 at 01:02 PM. Checked "yes" that R16 has assistive devices for eating. Surveyor reviewed the OT evaluation dated 03/2020. "Recommended using built up handle for feeding. Completes self feeding using built up handles requiring minimum physical assistance. Completes self feeding task using regular utensils requiring moderate physical assistance. Complete self feeding using built up handles requiring supervision." Surveyor interviewed the Registered Nurse (RN)24 who is taking care of R16 on 05/14/21 at 2:27 PM. Surveyor revealed that R16 was observed having a very difficult time eating independently. RN24 stated that" R16 gets the help he needs to eat from the staff." He also has special utensils that are built up. When asked where they are kept she stated they are kept in the kitchen. RN stated that R16 had his last fall	F 810		

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F 810	Continued From page 31 on March 28, 2021, he was being pushed in his wheelchair and he lunged forward and landed on his hands and knees. Surveyor stated to the RN that he was not observed using the built up utensils during observations made at meal times nor was he noted to have staff assisting him to eat. Surveyor reviewed residents Care plan on 05/14/21 at 03:48 PM. Use of built up utensils was not included on his care plan.	F 810		
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 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 observations, interview with staff member, and review of the facility's policy and procedure, the facility failed to ensure a food	F 812	1. Activities manager, dietary manager and DON were re-inserviced regarding food storage in unit□s nourishment	6/28/21

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F 812	Continued From page 32 product was discarded before the discard date. Findings Include: Review of the facility's policy and procedure for resident refrigerators, " ...nursing staff is responsible for discarding perishable foods on or before 3-day mark ..." Concurrent observation with Activities Manager (AM) on 05/12/21 at 12:01 PM, observed in Unit 2's nourishment room refrigerator, half of an egg sandwich saran wrapped in the refrigerator with a discard date of 05/11/21. AM stated the egg sandwich should not be in the refrigerator and needs to be discarded.	F 812	refrigerators by the SDC / designee. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by the alleged practice. 3. Dietary, Activity and Direct care staff were re-inserviced regarding the storage of food in the unit nourishment refrigerators by the SDC / designee. Inservices will be ongoing as needed. 4. DON / Dietary manager / Unit managers /designee will monitor for compliance through observations rounds 3 x weekly for a minimum of 12 weeks of until compliance is achieved. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee monthly for a minimum of 3 months or until compliance is achieved.	

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E 000	Initial Comments A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on 05/12/21 to 05/17/21. The facility met the Health Safety Requirements of Appendix "Z", for emergency preparedness and response; in accordance with 42 CFR 483.73 requirement for Long term care facilities	E 000		

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

Electronically Signed | 06/19/2021

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 A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	125046		**08/24/2021**

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K 000	INITIAL COMMENTS	K 000		
	A Life Safety Code survey was conducted by Healthcare Management Solutions, LLC on behalf of the Department of Health, Office of Health Care Assurance on 08/24/21. The Facility was found not to be in compliance with the requirements of 42 CFR 483.90. Pu'uwai 'O Makaha is a one-story nursing facility rated as a type V (111). Building 1 and Building 2 are constructed of the same type of materials with a ramp connector. Both buildings are wood frame roofing and bearing walls with a tile exterior roof and concrete slab floor. Building one was built in 1979 and building two was built in 1989. The facility has a 30 Kilowatt (KW) diesel generator that supplies back up emergency power to the entire complex.			
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the means of egress was maintained for one exit in Building 1 in accordance with NFPA 101 (2012 edition) section 7.1.10.1. This had the potential to affect 13 residents living in the area of the exit door.	K 211	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet	10/8/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/17/2021

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K 211	Continued From page 1 Findings include: Observations of the exit door near bedroom four in Building 1 on 08/24/21 at 10:20 AM revealed when vigorously pushed by the Administrator, the door would not open. Assistance with the door by the Director of Plant Operations finally freed the door and it opened on the fourth attempt. Interview with the Administrator at the time of the observation verified the door would not open and the Administrator indicated the door worked fine earlier in the day. The code requires under NFPA 101 (2012 Edition) section 7.1.10.1 "means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of a fire or other emergency."	K 211	requirements established by state and federal law. 1. Maintenance completed work on the exit door near bedroom four on 8/24/21 for ease of opening. 2. Facility residents have the potential to be affected by the alleged practice. 3. Maintenance & Housekeeping staff were in-serviced on appropriate Exit door access. 4. Maintenance Director / designee will complete weekly audits on exit doors for one month and then monitor through facility□s Preventative Maintenance Program. The results of the audits will be brought to the Quality Assurance / Performance Improvement committee until compliance is achieved. Administrator will ensure compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on review of fire alarm reports and interview, the facility failed to ensure that smoke detectors were tested in Building 1 and Building 2 in accordance with NFPA 72 (2010 edition)	K 345	1. Semi-annual smoke detection sensitivity tests were completed on 8/27/21. If any smoke detector tested for sensitivity does not meet within the ranges	10/8/21

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	125046		**08/24/2021**

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K 345	Continued From page 2 sections 14.4.5.3.2 and table 14.4.2.2. and failed to maintain duct detectors in accordance with NFPA 72 (2010 edition) section 14.2.1.2.1 This had the potential to affect all 60 residents living in both buildings. Findings include: Review of fire alarm inspection reports located in the facility fire safety binder dated most recent on 08/18/20 on 08/13/19 titled, "Fire Alarm and Life Safety System Inspection Certificate" revealed the reports lacked reference to smoke detection sensitivity reports in the past two years or 24 months. Interview on 08/24/21 at 12:15 PM with the Director of Plant Operations (DPO) revealed the reports were not completed and not available. The code requires at NFPA 72 (2010 edition) section 14.4.5.3.2 that smoke detection sensitivity tests "sensitivity shall be checked every alternate year unless otherwise permitted." Review of a fire alarm report titled, "Fire Alarm and Life Safety Inspection Certificate," dated 08/18/20 located in the fire safety binder revealed one duct detector located above nurse station two " ... has no power and is not being in use." A duct detector had been observed in the smoke barrier wall above the ceiling near bedroom 23. Due to the position of the device, it could not be determined if the device had power. Interview with the Administrator on 08/24/21 at 4:00 PM acknowledged the statement by the contractor and indicated the contractor has been scheduled this week and will review at that time.	K 345	established by the manufacturer, the smoke detector will be replaced immediately. The duct detector has been assessed and repair work has been scheduled for 9/23/21. 2. Facility residents have the potential to be affected by the alleged practice. 3. Maintenance Director was in-serviced on requirements for semi-annual smoke detection sensitivity testing and documentation as well as correcting any alarm system defects and malfunctions. 4. Maintenance Director / designee will report quarterly to the Quality Assurance / Performance Improvement committee for outcomes review and follow up. Administrator will ensure compliance.	

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K 345	Continued From page 3 The code requires under NFPA 72 (2010 edition) section 14.2.1.2.2 that "alarm system defects and malfunctions shall be corrected."	K 345		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure it maintained complete sprinkler coverage throughout the buildings in accordance with NFPA 13 (2010 edition) section 8.1.1. and section 8.15.7.1. This had the potential to affect the safety of all 60 residents. Findings include: Building 1:	K 351	1. Sprinkler system installation in the supply closet (front lobby), oxygen closet (Building 1), Exterior Canopy (near bedroom four) and electrical room (Building 2) has been scheduled for 9/24/21. 2. Facility residents have the potential to be affected by the alleged practice. 3. Maintenance Director was in-serviced on sprinkler system requirements.	10/8/21

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K 351	Continued From page 4 Observation of the closet near the two visitor bathrooms in the front lobby of Building 1 on 08/24/21 at 9:35 AM revealed a storage closet measuring 2 feet (ft) deep by 5 ft wide lacking sprinkler coverage. The room is a supply closet for desk materials for the facility. The room contained binders and paper supplies. Observation on 08/24/21 at 9:45 AM in Building 1 dining room revealed a room labeled oxygen storage which contained nine full oxygen tanks. The room measured 2 ft wide by 3 ft deep and lacked sprinkler coverage. The code requires under NFPA 13 (2010 edition) section 8.1.1. that "sprinkler coverage shall be installed throughout premises." Observation on 08/24/21 at 10:15 AM of the exterior canopy in Building 1 measuring 8 ft, 1 inch (in) wide by 8 ft, 1 in deep near bedroom four lacked sprinkler coverage. The code requires under NFPA 13 (2010 edition) section 8.15.7.1. that sprinklers are to be installed under exterior canopy projections exceeding 4 feet. Interview with the Administrator at the time of each of the above observations confirmed the lack of sprinkler coverage. Building 2: Observation of an electrical room in Building Two on 08/24/21 at 10:30 AM revealed the room measured 15 ft deep and 6 ft wide and lacked sprinkler coverage.	K 351	4. Maintenance Director / designee will report quarterly to the Quality Assurance / Performance Improvement committee for outcomes review and follow up. Administrator will ensure compliance.	

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	125046		**08/24/2021**

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K 351	Continued From page 5 Interview with the Administrator at the time of the observation verified the lack of sprinkler coverage in the electrical room in Building 2. The code requires under NFPA 13 (2010 edition) section 8.1.1. that "sprinkler coverage shall be installed throughout premises."	K 351		
K 352 SS=E	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to have electronic supervision for one of two main sprinkler control values for Building 2 in accordance with NFPA 13 (2010 edition) section 8.16.1.1.2. This had the potential to affect the safety of residents in Building 2. Findings include: Observation of a main sprinkler control valve on the exterior of Building 2 on 08/24/21 at 10:05 AM revealed the sprinkler control valve was secured from closing or shutting off by a chain and padlock. The sprinkler control valve lacked an electronic tamper switch or electronic supervision.	K 352	1. A tamper switch installation for the control value on Building 2 has been scheduled for 9/24/21. 2. Facility residents have the potential to be affected by the alleged practice. 3. Maintenance Director was in-serviced on the need for electronic monitoring of the sprinkler control valve. 4. Maintenance Director / designee will report quarterly to the Quality Assurance / Performance Improvement committee for outcomes review and follow up. Administrator will ensure compliance.	10/8/21

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	125046		**08/24/2021**

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K 352	Continued From page 6 Interview with the Director of Plant Operations 2 at the time of the observation verified the control valve had a lock and chain and lacked an electronic tamper switch. The code under NFPA 13 (2010 edition) section 8.16.1.1.2. requires, "Valves on connection to water supplies and other valves in supply pipes to sprinklers shall be supervised by a local signaling service that will cause the sounding of an audible signal at a constantly attended point."	K 352		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record reviews and interview the facility failed to test and maintain its sprinkler in	K 353	1. A contract for quarterly inspections by a qualified technician of the tamper and	10/8/21

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	125046		**08/24/2021**

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K 353	Continued From page 7 accordance with NFPA 25 (2011 edition) table 5.1.1.2. This had the potential to affect all 60 residents. Findings include: Review of the facility sprinkler system reports in the fire safety binder revealed the facility had one annual sprinkler system inspection and no quarterly sprinkler inspections in the past twelve months. The one sprinkler report titled, "Automatic Sprinkler System Test" annual report was dated 10/19/20. During an interview on 08/24/21 at 12:20 PM the Director of Plant Operations 2 stated the facility completes quarterly inspections but does not check the tamper switches or flow switches. The annual inspection completed on 10/19/20 reviewed all aspects of the facility system. The facility has no quarterly inspection by a qualified technician of the tamper and flow switches on the sprinkler system as required. The code requires under NFPA 25 (2011 edition) table 5.1.1.2 that on a quarterly, the waterflow device, alarm devices associated with the sprinkler system, and the valve supervisory system devices be checked.	K 353	flow switches on the sprinkler system has been put into place as of 9/14/21. 2. Facility residents have the potential to be affected by the alleged practice. 3. Maintenance Director was in-serviced on need for quarterly sprinkler inspections by a qualified technician. 4. Maintenance Director / designee will report quarterly to the Quality Assurance / Performance Improvement committee for outcomes review and follow up. Administrator will ensure compliance.	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is	K 916		10/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
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K 916	Continued From page 8 hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, fire safety record review, and interview, the facility failed to ensure that a remote alarm annunciator was available in a location readily available to personnel at a regular working station in accordance with NFPA 99 (2012 edition) section 6.4.1.1.16.2 and 6.4.1.1.17. This had the potential to affect all 60 residents. Findings include: Observations on the facility tour on 08/24/21 from 9:30 AM to 12:00 noon revealed no evidence of a remote annunciator panel anywhere in either of the two buildings. Interview with the Administrator on 08/24/21 at 11:15 AM revealed the facility does not have a remote annunciator for the 30-Kilowatt (KW) diesel powered generator with a type II EPSS (emergency power supply system). Review of the most recent generator maintenance report dated 11/13/20 located in the facility fire safety binder revealed no reference to checking of a remote annunciator during routine maintenance. The code under NFPA 99 (2012 edition) section 6.4.1.1.17 and 6.4.1.1.16.2 requires, "A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room at a location readily observed by operating	K 916	1. A remote alarm annunciator panel installation located in the front lobby (where staff are available 24 hours a day, 7 days a week) has been scheduled for 10/5/21. 2. Facility residents have the potential to be affected by the alleged practice. 3. Staff will be in-serviced on the location of the remote alarm annunciator panel and what the device means and what to do if or when the remote annunciator sounds. 4. Maintenance Director / designee will complete weekly checks for one month and then monitor through facility□s Preventative Maintenance program. The results will be brought to the Quality Assurance / Performance Improvement committee for outcomes review and follow up. Administrator will ensure compliance.	

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	125046		**08/24/2021**

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K 916	Continued From page 9 personnel at a regular workstation." 16.4.1.1.16.2 indicates the following warnings shall be present for the remote annunciator including, "overcrank, low water temperature, high engine temperature-pre alarm, high engine temperature, low lube oil pressure-pre-alarm, low lube oil pressure, overspeed, low fuel main tank, low coolant, EPS supplying load, control switch not in automatic position, high battery voltage, low battery cranking voltage, low voltage in battery, battery charger A/C failure, lamp test, contacts for local or remote common alarm, audible alarm silencing switch, low starting air pressure, low starting hydraulic pressure, air shutdown damper when used, remote emergency stop."	K 916		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in	K 918		10/8/21

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	125046		**08/24/2021**

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K 918	Continued From page 10 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, the facility failed to ensure the emergency generator was tested under load monthly and the transfer switch room had emergency lighting in accordance with NFPA 110 (2010 edition) section 7.3.2 and NFPA 99 (2012 edition) section 6.4.4.1.1.4 (a)(b). The had the potential to affect all 60 residents. Findings include: Observations of the generator room accessed on the outside of the building on 08/24/21 at 11:45 AM revealed the transfer switch/electrical room lack emergency lighting. Interview with the Director of Plant Operations (DPO) 2 at the time of the observation indicated there is no battery powered lighting in the room. The code under NFPA 110 (2010 edition) requires, "The level I or level II EPS (emergency power system) equipment location shall be	K 918	1. Battery powered emergency lighting was installed in the transfer switch/electrical room on 9/3/21. Maintenance will complete a 30-minute load test of the emergency generator on 9/22/21. 2. Facility residents have the potential to be affected by the alleged practice. 3. Maintenance Director was in-serviced on need for completing a monthly 30-minute load test. 4. Maintenance Director / designee will complete 30-minute load tests monthly including testing the emergency lighting in the transfer switch/electrical room and monitor through facility□s Preventative Maintenance program. The results will be brought to the Quality Assurance / Performance Improvement committee for outcomes review and follow up. Administrator will ensure compliance.	

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	125046		**08/24/2021**

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K 918	Continued From page 11 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 facility generator testing records in the fire safety binder revealed weekly generator inspections but no evidence of a monthly load test for 30 minutes. During an interview on 08/24/21 at 12:20 PM DPO2 revealed 30-minute monthly load tests had not been 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 State of Hawaii, Department of Health on 08/24/21.The facility was found to be in compliance with 42 CFR 483.73 (e) related to E-0041.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/17/2021

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.