STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	04/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA). The facility was found not to be in substantial compliance with 42 CFR 483 Subpart B. Survey Dates: April 14 to 19, 2021 Survey Census: 82 Sample Size: 18	F 000		
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 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	F 574		6/3/21

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

Electronically Signed | 05/14/2021

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F 574	Continued From page 1	F 574		

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;
(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

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F 574	Continued From page 2 directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on interviews and observations, the facility did not assure residents had knowledge of where the posting for names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies (State Long-Term Care Ombudsman, Adult Protective Services, and State Survey Agency) were located. The residents were also not aware that they may file a complaint with the State Survey Agency. This deficient practice prevents the facility's residents of knowing about their advocates and how to contact them and could potentially affect all residents in the facility. Finding includes: Interview was done with Resident Council (RC) representatives, resident (R)79 and R15, on 04/14/21 at 02:00 PM. When asked where the Ombudsman's contact information was posted, the residents were not aware of the role of an Ombudsman. Further queried whether they were aware that they can call the State Survey Agency with any complaints or concerns about the care they are receiving. The residents were not aware. Observations on the facility's units found postings about the Ombudsman; however, the posting of the pertinent State regulatory and information agencies was printed on an 8-1/2 by 11-inch sheet of paper and placed at the top of the bulletin board. The format of the information does not accommodate residents that are in wheelchairs or have visual impairments as	F 574	Corrective Action R79 and R15 were oriented on 5/07/2021 to the location of posting of names, addresses, and telephone numbers of all pertinent State regulator and information agencies and their roles (State Long-Term Care Ombudsman, Adult Protective Services, and State Survey Agency; formatted (changed font size) and posted the information in a way that residents in wheelchairs or those with visual impairments are able to see the print. Identification of others All residents have the potential to be affected by this practice. Education with Resident Council was initiated on 5/7/2021 on the location - posting of names, addresses, and telephone numbers of all pertinent State regulator and information agencies and their roles (State Long-Term Care Ombudsman, Adult Protective Services, and State Survey Agency). All residents will be educated by 06/03/2021 regarding location of posting of names, addresses, and telephone numbers of all pertinent State regulator and information agencies and their roles (State Long-Term Care Ombudsman, Adult Protective Services, and State Survey Agency). New admissions beginning 5/14/2021 will also receive a revised and updated copy of state agency	

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F 574	Continued From page 3 the posting was too high and the font too small. Also observed postings on a bulletin board at the entrance to the dining room; however, during the COVID-19 pandemic, residents were not being taken to the dining room for meals. On 04/19/21 starting at 11:05 AM, a concurrent observation was done with the Social Worker (SW)1 of both resident units. SW1 confirmed the placement of the information was too high for residents in wheelchairs and the font size was small.	F 574	information in the admission packet. Systemic Changes Effective 5/07/2021 Resident Council meeting agenda will include information regarding location - posting of names, addresses, and telephone numbers of all pertinent State regulator and information agencies and their roles (State Long-Term Care Ombudsman, Adult Protective Services, and State Survey Agency) in subsequent meetings. Monitoring for Changes The Executive Director or designee will interview 5 random residents per week x 4 weeks to ensure they are aware of location and information. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §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	F 577		6/3/21

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F 577	Continued From page 4 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 interviews and observations, the facility failed to assure residents were aware of the posting location of the State inspection results. One of the two RC representatives was aware of the State inspection report; however, did not know where the report was located. This deficient practice impedes the resident's right to be informed and could potentially affect all residents in the facility. Finding includes: An interview was conducted with RC representatives, R79 and R15, on 04/14/21 at 02:00 PM. Due to the COVID-19 pandemic, the RC had not been meeting regularly. The Activities Director (AD) reported during the pandemic, she had been meeting with the residents individually. The residents were asked whether they are aware of the right to review the results of the State inspection. R79 responded being aware of the State survey inspection report; however, was unable to recall where it was located.	F 577	Corrective Action R79 and R15 were oriented on 5/07/2021 to the location of State inspection results. Identification of others All residents have the potential to be affected by this practice. Education to Resident Council was initiated on 5/7/2021 on the of State Inspection results. All residents will be educated by 06/03/2021 regarding location of State Inspection results. Systemic Changes Effective 5/07/2021 Resident Council meeting agenda will include information regarding location of State Inspection results. Monitoring for Changes The Executive Director or designee will interview 5 random residents per week x 4 weeks to ensure they are aware of location and information. The results of	

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F 577	Continued From page 5 Observation on the afternoon of 04/14/21 found both units provided a binder containing the State survey results next to resident's bulletin board. Although the facility posts the results of the State inspection, resident representatives were not aware of where to find the report for their review.	F 577	the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		6/3/21

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F 580	Continued From page 6 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility did not assure Resident (R)283's representatives was notified of emesis (vomiting) episodes. This deficient practice prevents R283's family knowing the medical and physical status of their loved one. Finding includes: Cross reference to F684. During observations on 04/14/21 of R283 in her room, R283 was noted with two separate episodes (morning and midday) of emesis. A phone interview was conducted with two of R283's representatives in the afternoon of 04/14/21. Inquired whether they were informed of	F 580	Corrective action R283 was discharged from the facility on 4/16/2021. RN received 1:1 education on 4/19/2021 related to documentation, to include notifying family and MD on changes in medical status. Identification of others All residents who have changes in medical status are considered to be affected by this practice. Systemic Changes Staff education was initiated on 4/19/21 related to documentation, to include notifying family and MD on changes in medical status. Changes of medical status are discussed in grand rounds, and	

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F 580	Continued From page 7 R283 vomiting. Both representatives responded they were not aware R283 was vomiting. The representatives confirmed that they are the contact for any changes.	F 580	nursing leadership will inquire if family and MD have been notified of change. Monitoring Changes The Director of Nursing or designee will conduct 5 random resident audits per week x4 weeks to ensure proper notification and documentation to MD and family regarding medical status changes. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	
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 treatment under §483.10(c)(6).	F 656		6/3/21

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F 656	Continued From page 8 (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 interviews and record reviews (RR), the facility failed to document R20's toothache on his care plan. This deficient practice could have resulted in a worst outcome for R20 due to the facility's lack of follow up with his pain and could potentially affect all the residents in the facility. Finding includes: Cross reference to F791. An initial interview was done with R20 on 04/14/21 at 03:20 PM in his room. R20 stated, "Last week I had a toothache." He further stated that he saw a dentist a couple of weeks prior to the toothache, but his tooth was not hurting then. He used a "prescription mouthwash" to treat the	F 656	Corrective Action R20 was seen by facility dentist for follow up of tooth pain on 4/20/2021, and has had weekly follow ups since then. R20 care plan updated on 5/6/2021 to reflect dental status, including intermittent pain. 1:1 Education completed on 5/5/2021 with Unit Manager regarding follow up on toothache and ensuring to follow emergency dental services policy, to include updating care plan timely. Identification of others All residents with tooth pain have the potential to be affected by this practice. One other resident currently residing in facility with complaint of toothache. Dental	

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F 656	Continued From page 9 toothache, but staff took it away because it was a prescription medication without a doctor's order. He also stated that he did alert staff about his need for a dentist, but there had been no follow up by staff for a dentist to assess his tooth pain. R20 stated that he did not have a dentist and he had been waiting for a dental appointment. A review of R20's electronic health record (EHR) on 04/16/21 at 08:00 AM, revealed that he was a 56-year-old male admitted for cellulitis (inflammation of underlying skin) of his right leg and muscle weakness and receiving physical therapy. Review of his care plan revealed that there was no entry for his toothache. The progress notes of his EHR showed "Orders - Administration Note" for Acetaminophen Tablet (pain reliever medication) 325 mg (milligrams) for toothache. Nurses had administered this medication to him for this complaint and monitored for its effectiveness. The progress notes further revealed a "Health Status Note" documented on 04/12/21 at "15:49" (3:49 PM) stated, "Bottle of Orajel (contains numbing medication used for minor mouth and gum irritation) mouthwash found at resident's bedside. Resident stated he ordered Orajel for toothache relief. Reported during grand rounds and instructed by DON (Director of Nursing) to remove Orajel bottle from resident's possession while awaiting orders from MD (Medical Doctor)." The following progress note showed "Orders - Administration Note" documented on 04/13/21 at "14:29" (2:29 PM), "May use 10 (ten) CC (cubic	F 656	appointment scheduled for 5/13/2021. Comprehensive care plan reflects toothache and follow up interventions. Systemic Changes Staff education initiated on 4/19/2021 regarding reporting during grand rounds and/or shift to shift report of any complaints of medical status change to include dental concerns and updating the care plan. Nursing leadership to review documentation and ensure care plans are updated accordingly. Monitoring for Changes The Director of Nursing or designee will interview 5 random chart reviews per week x 4 weeks to ensure care plans are updated reflecting any dental concerns. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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F 656	Continued From page 10 centimeters, equivalent to milliliters) of own supply of Orajel Analgesic (pain reliever medication) mouth rinse every 12 hours as needed for Tooth pain located in med cart." Review of R20's EHR did not reveal that his toothache was resolved. An interview with the Registered Nurse Unit Care Coordinator (RN UCC)3 was done on 04/19/21 at 1:15 PM at the nursing station. When queried about why R20's toothache was not care planned, she stated that after R20 used his Orajel mouthwash, he stated his toothache was better. An interview was conducted with SW1 on 04/19/21 at 01:46 PM in her office. She stated that the dentist did his annual rounds on the facility's residents on 03/27/21 and assessed R20 but found no problems. She stated that she was unsure if R20 had complained about a toothache and would "have to check" and get back to the surveyor. SW1 did not return to the surveyor with an answer. In a follow up query with SW1 on 04/19/21 at 04:00 PM while the surveyor was exiting the dining room, she stated that R20 had a dental appointment for the following day.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and	F 679		6/3/21

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F 679	Continued From page 11 individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and RR, the facility failed to ensure there was an ongoing resident-centered activities program that fully identified the residents' needs, for two residents in the sample, R74 and R182. Specifically, the facility failed to act on the residents' need for social engagement, failed to implement activities the residents found meaningful, and failed to develop an activities program that included the residents' stated interests. As a result of this deficient practice, R74 and R182 experienced a decline in their psychosocial well-being as evidenced by their feelings of distress, loneliness, and isolation. This deficient practice has the potential to affect most residents at the facility. Findings include: 1) R74 was an 82-year-old female admitted on 03/24/21 for short-term rehabilitation (STR) following a stroke. On 04/14/21 at 11:00 AM, an interview was done with R74 in her room. R74 stated that since arriving at the facility, she often feels isolated, and does not like the amount of time she has to spend in her room. R74 went on to explain that the only time she leaves her room is for visits once or twice a week, and for therapy. She also expressed frustration that the visits are only twenty minutes long. R74 stated she would like to have activities to do or some type of social interaction, but it was never offered to her.	F 679	Corrective Action R74 participated with group dining on 4/23/21, 4/30/21. Per resident's request, Activities set up new IPad so that she was able to Facetime husband daily, resident also had in-person visits with husband 2-4 times a week. Resident was seen daily by activities to provide conversation per her preference. R74 was discharged on 5/10/21. R182 offered to participate in group dining on 4/19/21 and 4/23/21 but resident declined both times. Resident was provided 1:1 visits daily and resident would refuse at times. R182 was moved to bed B closer to window per request so that resident was able to see out of window, specifically to watch the birds. R182 was discharged on 5/5/21. Identification of others All residents have the potential to be affected by this practice. Room-to-room audit for all residents not on transmission based precautions able to participate with group dining completed on 4/19/21, 4/23/21, 4/30/21 and ongoing. Systemic Changes Effective 4/23/21 Dining room was open for Short Term Rehab (STR) unit for group dining. In addition to dining, group activities initiated on 5/11/21.	

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F 679	Continued From page 12 On 04/14/21 at 11:20 AM, an interview was done with Activities Aide (AA)1 outside by the fountain in the front courtyard. AA1 stated that group activities were done with the residents on the long-term care (LTC) wing, while the residents on the STR wing did individual activities. STR resident activities included word search puzzles, playing cards, newspaper, and crochet. AA1 stated that an Activities Aide visited each resident on the STR wing daily. On 04/15/21 at 09:16 AM, in an interview with R74 she was asked if anyone ever came in to offer her newspapers, books, or puzzles. R74 answered, "(they) came in once and offered me a section of the newspaper." R74 said that she would love to just sit and talk to people and would jump at the chance to eat in the dining room, but her only exposure to other residents is sometimes on her way to and from therapy, in passing. She stated she feels very isolated and a bit lonely. R74 had a roommate, but social interaction was very limited due to her roommate's diagnoses. On 04/16/21 at 11:24 AM, an interview was done with RN UCC1 at the nurses' station. The RN UCC1 acknowledged that residents from the LTC wing were able to take their meals in the dining room, on a rotating basis, but the STR residents had not been offered that opportunity. When asked why not, RN UCC1 stated that she did not know. On 04/16/21 at 01:27 PM, an interview was done with the Activities Director (AD) in the conference room. The AD confirmed that although limited group activities had started in "January, February" on one side of the facility, it had not been opened	F 679	Activities Director will ensure MDS activities assessment matches participation record with resident's stated interest. Monitoring for Changes The Executive Director or designee will review 5 charts per week x 4 weeks to ensure MDS activities assessment matches participation record with resident's stated interest. 5 Random residents per week x 4 weeks will be interviewed if they are being offered activities that interest them. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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to include the STR residents yet. The AD stated that there were no activities calendars posted either, "because there are no set activities." Group activities occur on a rotating basis, as time and staffing allowed, on the LTC resident wing only.

In R74's RR, her Minimum Date Set (MDS), Admission Assessment, dated 03/31/21, her activity preferences were marked "very important" to R74 that she do things with groups of people, and that she be allowed to spend time outside when the weather was good. A review of R74's Comprehensive Care Plan (CP), dated 03/31/21, revealed the following planned intervention: "Provide a program of activities that is of interest and empowers ...(R74) by encouraging/allowing choice, self-expression and responsibility."

2) R182 was a 92-year-old female admitted on 03/27/21 for STR following a wedge compression fracture (a fracture of her spinal vertebrae). During an interview with R182 on 04/14/21 at 01:24 PM in her room, R182 stated that she used to enjoy watching the birds outside the window in her old room. She was moved to her current room and she can no longer see any birds. No one has offered to take her walking outside, to participate in any group activities, or asked if she wanted to eat in the dining room. Stated since being moved to this room, she is very tired all the time, and does not want to get out of bed, not even to eat or shower. R182 then went on to say, "I just want to go already." When asked where she wanted to go, R182 pointed upwards, closing her eyes. When asked if she meant heaven, R182 responded "yes."

In R182's RR, her MDS Admission Assessment,

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F 679	Continued From page 14 dated 04/03/21, her activity preferences indicated that it was "very important" to R182 that she do things with groups of people, and that she be allowed to spend time outside to get fresh air when the weather was good. A review of R182's CP, revealed the following planned intervention initiated on 04/07/21: "Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility."	F 679		
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 observations, RR and interviews, the facility failed to assure that R283 was provided with care and services that are resident centered and meets each resident's highest practicable physical needs. R283 was observed with two episodes of nausea and emesis (vomiting) and there was no documentation in the progress notes regarding these episodes. Also, there was no documentation that the resident's physician was notified to evaluate and, if indicated, determine a treatment course. This deficient practice could result in potentially affecting all the facility's residents.	F 684	Corrective action R283 was discharged from the facility on 4/16/2021. RN received 1:1 education on 4/19/2021 related to documenting and notifying family and MD on changes in medical status. Identification of others All residents who have changes in medical status are considered to be affected by this practice. Systemic Changes Staff education was initiated on 4/19/21	6/3/21

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F 684	Continued From page 15 Finding includes: Cross reference to F580. R283 was admitted to the facility on 04/04/21. Admission diagnoses include cellulitis (inflammation of underlying skin) of left and right lower limb; contact with and (suspected) exposure to COVID-19; muscle weakness; gastro-esophageal reflux disease (GERD) without esophagitis (food pipe inflammation); mild-protein-calorie malnutrition; personal history of other malignant neoplasm (cancerous tumor) of stomach; and acute chronic diastolic (congestive) heart failure. Observed R283 lying on her bed in her room holding a clear plastic receptacle which contained yellow fluid during the initial screening of residents on 04/12/21 at 09:30 AM. R283 was observed holding the receptacle over the left side of the bed. R283 reported feeling nauseous. Second observation at 12:40 PM found R283 in bed with the receptacle containing brown fluid with solid particles in the fluid. The receptacle was on the overbed table next to resident's lunch tray. Inquired whether she felt nauseous, R283 replied she would attempt to eat some lunch. On 04/16/21 at 08:10 AM observed R283 sitting up in bed with breakfast tray, the clear receptacle was placed on the resident's overbed table. On 04/12/21 at 12:20 PM, Registered Nurse (RN)1 reported R283 had been complaining of nausea and had vomited. RN1 also reported waiting on the resident's physician for medication to address nausea.	F 684	related to documenting and notifying family and MD on changes in medical status. Changes of medical status are discussed in grand rounds, and nursing leadership will inquire if family and MD have been notified of change. Monitoring Changes The Director of Nursing or designee will conduct 5 random resident audits per week x4 weeks to ensure proper notification and documentation to MD and family regarding medical status changes. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained	

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On 04/14/21 at 03:00 PM, phone interviews with R283's representatives were done. The representatives reported that the facility did not inform them of R283 vomiting.

A RR of R283's chart was done on 04/16/21 at 07:40 AM. The physician orders which include Calcium Carbonate antacid, 750 (milligram, mg) tablet, every four hours for GERD, indigestion; Augmentin 500-125 mg, give one tablet by mouth two times a day for cellulitis for 7 (seven) days; and Pantoprazole sodium tablet delayed release, 40 mg, give one tablet by mouth one time a day for GERD.

A review of the Medication Administration Record (MAR) found antacid was administered on 04/14/21 at 02:37 PM and at 07:30 PM which were documented as effective. On 04/15/21 antacid was administered at 07:38 PM, which was documented as effective. R283 was observed with emesis on 04/14/21 at 09:30 AM and 12:40 PM, antacid was not administered until 02:37 PM.

The facility developed a care plan for GERD with the goal for the resident to remain free from discomfort, complication or signs/symptoms related to GERD. The interventions/tasks include: avoid activities that involve bending, lifting; avoid snacks that aggravate the condition; avoid lying down for at least one hour after eating, keep head of bed elevated, encourage to stand/sit upright after meals; avoid overeating, provide small frequent meals rather than 3 large ones, encourage the resident to take their time eating, alternate food with sips of fluids; dietary, avoid foods or beverages that tend to irritate esophageal lining; give medications as ordered;

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and lab/diagnostic work as ordered, report results to physician and follow up as indicated. There are no interventions to address GERD with vomiting.

Review of the progress notes found no entry related to R283's vomiting. There was no documentation of frequency, description and volume of vomitus and resident's status (nausea, food consumption, fluid intake). There was no documentation that R283's physician was notified to assess and determine treatment course if needed.

On 04/19/21 at 08:20 AM interview was conducted with RN UCC1. Inquired whether there are progress notes related to R283 vomiting on 04/14/21. RN UCC1 reported she does not see documentation of the vomiting in the progress notes; however, agreed to contact RN1. Further queried where R283's physician documents notes are located. RN UCC1 responded that the physician's notes are in the resident's paper chart. A RR of R283's paper chart at 08:35 AM found no documentation by the physician related to emesis episodes.

On 04/19/21 at 10:35 AM an interview was conducted with the DON. The DON reported that the RN UCC1 was asked to follow up with RN1. The DON confirmed GERD with reflux, something out of the ordinary requires notification to the doctor and family.

On 04/19/21 at 01:51 PM, RN UCC1 reported R283 was provided with Tums (antacid) which was effective, so the resident's physician was not notified.

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F 684	Continued From page 18 During a RR on 04/19/21 at 08:35 AM, it was documented that on 04/16/21, R283 complained of chest pain and was provided with three doses of nitroglycerin (medication to help blood flow to the heart). Administration of the nitroglycerin was ineffective, R283 was sent to the hospital emergency department.	F 684		
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 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 and interview, the facility	F 761	Corrective Action	6/3/21

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F 761	Continued From page 19 failed to ensure all medications used in the facility were labeled with easily identifiable expiration dates and identifiable medication names. Proper labeling of medications is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice had the potential to affect all residents in the facility. Findings include: 1) On 04/16/21 at 08:30 AM, while observing a medication pass with RN2 outside of Room 506, it was noted that medication expiration dates were not visible on the blister packs RN2 was extracting medications from. The top front of each blister pack contained the pharmacy label with clearly identifiable information, but no identified expiration date. When RN2 was asked to point out the expiration dates, she was unable to identify any. RN2 asked RN UCC2 if he was able to identify the expiration date on the label, but he was also unable to. RN UCC2 then called over RN UCC1 who pointed to some indecipherable scribbles written in black ink on the lower half of the pharmacy label and said that that was the expiration date. 2) On 04/16/21 at approximately 08:35 AM, another observation was done at the medication cart outside Room 506. RN2 was preparing Humulin 70/30 insulin (medication for high blood sugar) pen for a resident. The pharmacy label covered the name of the insulin contained inside. When RN2 was asked how she confirmed that the insulin she was about to give was Humulin 70/30, she confirmed that she could not. RN2 then proceeded to carefully peel off the pharmacy label and moved it down enough so that she	F 761	On 4/16/2021 RN2 and RNUCC2 were educated on location of expiration date on medication labels.On 4/16/21 ED reached out to Lead Pharmacist at PharMerica regarding concern of legibility on expiration dates. Further follow up with ED, DON, and PharMerica's pharmacy nurse consultant on 5/6/2021 to discuss proper labeling placement and importance of expiration dates legibility. Identification of others All residents have the potential to be affected by this practice. Systemic Changes Pharmacy nurse consultant/designee will initiate education with pharmacist and pharmacy techs on 5/07/2021 regarding proper label placement and legible expiration dates; Facility education initiated on 5/6/2021 with licensed nurses regarding placement of medication label, expiration date location, and ensure legibility, upon receiving medication delivery. Monitoring for Changes The Director of Nursing or designee will conduct 5 random medication label audits per week x 4 weeks to ensure legible expiration dates and correct label placement. The Director of Nursing or designee will also conduct 5 random nurse interviews to determine if they know location of expiration date on medication labels. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement	

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F 761	Continued From page 20 could match the name of the insulin to the pharmacy label and the physician order. On 04/16/21 at 08:45 AM, interviews were done with both RN UCC1 and RN UCC2 at the nurses' station. Concerns with medication expiration dates and pharmacy labels covering up product names were discussed, and they both agreed that labels should not be blocking the name of medications, especially for insulin, and that the pharmacy should have made it clearer what the expiration dates are, and where they are located, on the blister packs.	F 761	(QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer	F 791		6/3/21

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F 791	Continued From page 21 residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interviews and RR, the facility failed to provide R20 with a follow up to his complaints of a toothache. This deficient practice could have resulted in a worst outcome for R20 due to the facility's lack of follow up with his pain and could potentially affect all the residents in the facility. Finding includes: Cross reference to F791. An initial interview was done with R20 on 04/14/21 at 03:20 PM in his room. R20 stated, "Last week I had a toothache." He further stated that he saw a dentist a couple of weeks prior to the toothache, but his tooth was not hurting then. He used a "prescription mouthwash" to treat the toothache, but staff took it away because it was a	F 791	Corrective Action R20 was seen by facility dentist for follow up of tooth pain on 4/20/2021, and has had weekly follow ups since then. 1:1 Education completed on 5/5/2021 with Unit Manager regarding follow up on toothache and ensuring to follow emergency dental services policy, to include updating care plan timely. Identification of others All residents with tooth pain have the potential to be affected by this practice. During grand rounds, 3 other residents were identified on 5/6/2021 with dental concerns, appointments with dentist was scheduled for all 3 residents.	

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F 791	Continued From page 22 prescription medication without a doctor's order. He also stated that he did alert staff about his need for a dentist, but there had been no follow up by staff for a dentist to assess his tooth pain. R20 stated that he did not have a dentist and he had been waiting for a dental appointment. A review of R20's electronic health record (EHR) on 04/16/21 at 08:00 AM, revealed that he was a 56-year-old male admitted for cellulitis (inflammation of underlying skin) of his right leg and muscle weakness and receiving physical therapy. Review of his care plan revealed that there was no entry for his toothache. The progress notes of his EHR showed "Orders - Administration Note" for Acetaminophen Tablet (pain reliever medication) 325 mg (milligrams) for toothache. Nurses had administered this medication to him for this complaint and monitored for its effectiveness. The progress notes further revealed a "Health Status Note" documented on 04/12/21 at "15:49" (3:49 PM) stated, "Bottle of Orajel (contains numbing medication used for minor mouth and gum irritation) mouthwash found at resident's bedside. Resident stated he ordered Orajel for toothache relief. Reported during grand rounds and instructed by DON (Director of Nursing) to remove Orajel bottle from resident's possession while awaiting orders from MD (Medical Doctor)." The following progress note showed "Orders - Administration Note" documented on 04/13/21 at "14:29" (2:29 PM), "May use 10 (ten) CC (cubic centimeters, equivalent to milliliters) of own	F 791	Systemic Changes Staff education initiated on 4/19/2021 regarding reporting during grand rounds and/or shift to shift report of any complaints of medical status change to include dental concerns. Nursing leadership to review documentation and ensure residents are seen in a timely manner (within 72 hours) or documentation of PO intake and pain until follow up appointment. Monitoring for Changes The Executive Director or designee will interview five random residents per week x 4 weeks to determine if appropriate interventions and follow up completed in a timely manner. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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F 791	Continued From page 23 supply of Orajel Analgesic (pain reliever medication) mouth rinse every 12 hours as needed for Tooth pain located in med cart." Review of R20's EHR did not reveal that his toothache was resolved. An interview with the RN UCC3 was done on 04/19/21 at 1:15 PM at the nursing station. When queried about why R20's toothache was not care planned, she stated that after R20 used his Orajel mouthwash, he stated his toothache was better. An interview was conducted with SW1 on 04/19/21 at 01:46 PM in her office. She stated that the dentist did his annual rounds on the facility's residents on 03/27/21 and assessed R20 but found no problems. She stated that she was unsure if R20 had complained about a toothache and would "have to check" and get back to the surveyor. SW1 did not return to the surveyor with an answer. In a follow up query with SW1 on 04/19/21 at 04:00 PM while the surveyor was exiting the dining room, she stated that R20 had a dental appointment for the following day.	F 791		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		6/3/21

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F 880	Continued From page 24 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 25 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the correct hand hygiene procedure was followed, and that soiled laundry was stored properly. This deficient practice could potentially spread infections throughout the facility and affect residents, staff and visitors. Findings include: 1) On the morning of 04/14/21, RN UCC1 provided orientation to the COVID-19 unknown status resident unit staff members. RN UCC1 instructed them to don gown and gloves when entering residents' rooms. The RN UCC1 also instructed to use the "purple gown" which is stored on the clean linen cart which also contains resident gowns. Observation on 04/14/21 at 10:00 AM on the COVID unknown status resident unit, Certified	F 880	Corrective Action 1. Staff education was initiated on 5/5/21 regarding proper donning and doffing procedure. Staff inservice scheduled on 2. Triple linen sorter middle bin, cover was replaced on 4/14/21. Identification of Others All residents have the potential to be affected by this practice. A 100% audit was completed by Housekeeping supervisor on 4/14/2021 ensuring all soiled linen cart lids were covered and functioning properly. Systemic Changes 1. Infection Preventionist initiated education regarding donning and doffing procedures, hand hygiene and linen management.	

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F 880	Continued From page 26 Nurse Aide (CNA)1 wheeled R80 back to the unit. CNA reported R80 was returning to the unit after being weighed. CNA went to the covered clean laundry cart, removed a cloth gown then performed hand hygiene with alcohol-based hand sanitizer. CNA donned the cloth gown, performed hand hygiene and donned gloves. Observed signage posted on the unit for donning personal protective equipment (PPE). The procedural instructions for the donning of PPE include: hand hygiene, gown, hand hygiene, gloves. On 04/19/21 at 09:33 AM, interview was done with Infection Preventionist (IP) in the conference room. Inquired whether staff are to perform hand hygiene prior to removing a gown from the linen cart. IP confirmed hand hygiene should be performed before taking a gown from the clean linen cart. 2) On 04/14/21 at 09:06 AM in the hallway between rooms 103 and 105, surveyor observed a triple linen sorter with the bin on the left covered and labeled "Soiled Linen", the middle bin without a cover or label, and the bin on the right covered and labeled "Resident Personal Linen." Inside the middle bin without a cover or label was a wet white towel. In a concurrent observation and interview with CNA2 on 04/14/21 at 09:12 AM in the hallway, CNA2 stated the middle bin is for soiled linens and should be covered. CNA2 proceeded to look around the bin then walked away leaving the bin uncovered. A subsequent observation on 04/14/21 at 09:41 AM found the middle bin was still left uncovered.	F 880	2. Staff education was initiated on 5/5/21 of reporting broken equipment related to infection control. 3. RCA initiated regarding infection control findings. Monitoring Changes The Director of Nursing or designee will conduct 5 staff random audits per week x4 weeks to ensure staff are properly donning and doffing PPE. The Executive Director or designee will conduct 5 random cart audits per week x4 weeks to ensure all soiled linen cart lids are covered and functioning properly. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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F 880	Continued From page 27 In an interview with the Infection Preventionist (IP) on 04/19/21 at 09:34 AM in the conference room, she stated that the linen separator bins should be covered to contain the bacteria from soiled laundry.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 883		6/3/21

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F 883	Continued From page 28 (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and RR, the facility failed to ensure that all residents who were eligible for the influenza immunization received it. Coupled with advanced age and chronic conditions, this deficient practice made R74 especially vulnerable to the influenza virus and placed her at an increased risk of developing flu-related complications, such as pneumonia. This deficient practice has the potential to affect residents at the facility. Finding includes: On 04/19/21 at 10:20 AM, an interview was done with the IP while standing in front of the resident	F 883	Corrective action R74 was aware that she did not receive Influenza Vaccine. An audit was completed on 4/13/2021, R74 was the only identified resident who was eligible for the vaccination and didn't receive it. R74 was discharged from facility on 5/10/2021. Identification of others All residents are affected by this practice. Influenza vaccination season runs from October 1 to March 31 the following year. R74 was the only identified resident that had consented to vaccine but did not	

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F 883	Continued From page 29 unit's nourishment room. Per the IP, the influenza (flu) immunization was offered to staff and residents during the flu season, which had ended on 03/31/21. For 2021, the priority for new admissions was to offer the COVID-19 vaccine first, then the influenza vaccine, however the two could not be given within fourteen days of each other. A RR of R74's immunization record revealed that she had received her second dose of the COVID-10 vaccine on 02/13/21. It also indicated that she did not have an adverse reaction to the influenza immunization, but she was documented as "Not Eligible" to receive it. Documents in R74's paper chart noted that R74 was admitted on 03/24/21 and had signed a consent for the influenza immunization on 03/25/21. On 04/19/21 at 10:53 AM, an interview was done with the RN UCC1 at the nurses' station. RN UCC1 stated that R74's consent for the influenza immunization was not noticed in her paper chart until 04/13/21. The end of the flu season was 03/31/21 so the flu vaccine was not given to R74, and "Not Eligible" was documented on her immunization record. RN UCC1 stated there was no excuse for the consent to go unnoticed for so long and confirmed that per the facility's policy, R74 should have received the immunization.	F 883	receive it. Systemic Changes On 5/11/2021, the Interdisciplinary Team met and revamped current process. Upon admission, the admissions department completes Immunization Consent for Influenza and Pneumococcal vaccine with RP and or resident, and then will flag consent in chart, notifying nursing staff. Monitoring Changes The Director of Nursing or designee will conduct 5 random chart audits per week x4 weeks to ensure residents who were eligible and consented for the Pneumococcal vaccine were administered the vaccine. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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E 000	Initial Comments The facility was found in compliance with Section 483.73, Requirement for Long Term Care (LTC) Facility Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual.	E 000		

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

Electronically Signed | 05/14/2021

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 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Management Solutions, LLC on behalf of the Department of Health, Office of Health Care Assurance on August 19, 2021. The Facility was found not to be in compliance with the requirements of 42 CFR 483.90. Ka Punawai Ola is a one-story skilled nursing facility. The facility was constructed in early 1998 of composite wood exterior, wood frame roofing and bearing walls with tile roofing surface and concrete slab flooring. The facility has a 80 KW propane generator that supplies back up power to the entire building.	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit discharges in four locations are in accordance with CMS S&C letter 05-38 dated 07/24/05 including exits from units 400, 500, 300 and the main therapy room. This had the potential to affect the safe exit of the 43 residents residing on the units in proximity to the exits and participating in therapy. Findings include:	K 271	I. Facility to contract with construction company to create a hard surface to the public way, specifically providing exit 400, 500, 300, and main therapy room. II. A facility walk thru conducted on 9/13/2021 by Executive Director validated that all other exit points (100, 200 and 600 halls) have a hard surface access to public way.	10/3/21

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K 271	Continued From page 1 Observation on 08/19/21 at 9:40 AM of the exit discharge off the 500 unit near bedroom 514 revealed no hard surface to the public way. After the 8 feet (ft) by 10 ft concrete slab, there was a non-hard surface consisting of 50 ft of grass to the public way including passage through a locked gate. Observed the facility emergency floor plan posted on the wall which described the door as an exit. In addition, there was an emergency exit only sign posted on the door. Observation on 08/19/21 at 9:50 AM of the exit door off the 400 unit near bedroom 408 revealed it lacked a hard surface to the public way for 75 yards. After the 4 ft by 4 ft concrete slab, there was 75 yards of grass and large tree roots to the public way. Observed the facility floor plan which labeled the door as an exit and there was an illuminated exit sign above the door. Observation on 08/19/21 at 10:20 AM of the exit door off the main physical therapy area revealed it lacked a hard surface to the public way for over 100 yards. After the 4 ft by 4 ft concrete slab there was over 100 yards of grass and large tree roots to the public way. Observed the facility floor plan which labeled the door as exit and there was an illuminated exit sign above the door. Observation on 08/19/21 at 10:25 AM of the exit door off the 300 unit near bedroom 303 revealed it lacked a hard surface to the public way. The path is grass with large tree roots and extends over 100 feet to the public way. Observed the facility floor plan which labeled the door as exit and there was an illuminated exit sign above the door. Interview with the Assistant Maintenance Director	K 271	III. Facility contracted with local company to start project on 9/27/2021 with an expected completion date of no later than 10/8/2021. The construction in back of the building will include the addition of a four feet wide and four inches thick concrete sidewalk totaling up to 400ft. This would provide exits to 400, 500, 300, and the main therapy room. IV. Weekly update will be reported to QAPI subcommittee on the progress of construction project, until completion of project. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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K 271	Continued From page 2 at the time of each of the above observations verified the lack of hard surface to the public way The code requires under CMS S&C letter 05-38 dated 07/24/05 that "exit discharges are required to have a hard surface to the public way."	K 271		
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 record review of fire alarm reports and interview, the facility failed to ensure that smoke detectors were inspected and tested in accordance with NFPA 72 (2010 edition) sections 14.4.5.3.2 and table 14.4.2.2. This had the potential to affect the safety of all 80 residents in the event of a fire. Findings include: Record review of fire alarm inspection reports in the fire safety binder dated most recently on 04/30/21 and 01/16/19 revealed the reports did not address smoke detection sensitivity in the past two years or 24 months. During an interview on 09/19/21 at 2:50 PM the Assistant Maintenance Director stated the report	K 345	I. Smoke detection sensitivity test is scheduled for 9/29/2021. II. All residents have the potential to be affected. III. Executive Director educated maintenance staff regarding requirement to perform a Smoke detection sensitivity test on 9/13/2021. Education included to update tracking system to include inspection every 24 months to satisfy requirements. Contract established with local company on 9/16/2021 to perform annual inspection moving forward. Upon inspection on 9/29/2021, the facility will work with the contracting company to	10/3/21

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K 345	Continued From page 3 would be in the large binder if it were completed. Review of the binder revealed no smoke detection sensitivity report. 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." The code also requires annual testing of the smoke detection system and bi-annual visual inspections of the smoke detection system according to NFPA 72 (2010 edition) table 14.4.2.2.	K 345	replace any defective smoke detectors that does not pass the sensitivity test. Detectors will be replaced at the time of inspection, or on/before 10/3/2021, depending on parts availability. IV. The Executive Director/designee will report the results of the 9/29/2021 inspection related to smoke detectors passing/not passing the sensitivity test; and what will be done to correct the deficiency, if any. The above information will be reported on our next QAPI committee and every annual inspection thereafter to ensure compliance is achieved and maintained.	
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	K 353		10/3/21

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K 353	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review of fire safety reports and interview revealed the facility failed to test and maintain its sprinkler in accordance with NFPA 25 table 5.1.1.2. This had the potential to affect the safety of all 80 residents. Findings include: Review of the facility sprinkler system reports in the fire safety binder dated 10/27/20 revealed the facility had one annual sprinkler system inspection in the past twelve months and prior to that on 10/30/19. The facility has no quarterly sprinkler reports. Interview with the Assistant Maintenance Director on 08/19/21 at 2:50 PM indicated the sprinkler report would be in the large binder. Review of the large binder revealed two annual reports in the past two years. Because the quarterly sprinkler inspections/reports are not available or not completed, the facility electronic tamper switches have not been checked. The code under NFPA 25 table 5.1.1.2 requires inspection on a quarterly basis of the waterflow device, alarm devices associated with the sprinkler system, and the valve supervisory system devices. The annual inspections require bracing inspections, pipes and fittings and all sprinkler heads	K 353	I. Sprinkler inspection is scheduled for 9/29/2021. II. All residents have the potential to be affected. III. Executive Director educated maintenance staff on 9/13/2021 regarding requirement for quarterly testing of the sprinkler system. Education also included revising current tracking system to include quarterly sprinkler tests/inspection. Contract established with local company on 9/16/2021 to perform quarterly inspection moving forward. IV. The Executive Director/designee will report the results of the 9/29/2021 inspection related to findings and what will be done to correct the deficiency, if any. The above information will be reported on our next QAPI committee and after every quarter inspection thereafter to ensure compliance is achieved and maintained.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than	K 363		10/3/21

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K 363	Continued From page 5 required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on surveyor observation and interview, the facility failed to ensure that corridor doors	K 363	I. Bedroom doors 503 and 508 fixed on 8/31/2021, now closing and latching into	

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K 363	Continued From page 6 were without impediments to closing or latched into the frame in accordance with NFPA 101 (2012 edition) section 19.3.6.3. This had the potential to affect 16 residents on the 500-unit smoke zone. Findings include: Observations of bedroom door 508 on 08/19/21 at 9:35 AM revealed the door when closed by the surveyor, did not latch into the frame. Three attempts were made for the door to latch into the frame and none were successful. Interview with the Assistant Maintenance Director at the time of the observation verified that bedroom door 508 did not latch into the frame. Observations of bedroom door 503 on 08/19/21 at 9:40 AM revealed when closed by the surveyor, the door was dragging severely on the carpet, impeding the door closing. Interview with the Assistant Maintenance Director at the time of the observation verified the door 503 was dragging on the carpet. The code requires under NFPA 101 (2012 edition) section 19.3.6.3. that corridor doors shall close and latch into the frame.	K 363	the frame. II. All residents have the potential to be affected. Facility - wide audit completed on corridor doors on 8/19/2021 with no additional findings. On 9/17/2021, another facility wide audit was conducted and found 1 door not latching, which was adjusted and corrected by maintenance staff. III. Staff education initiated on 9/15/2021 regarding impediments to closing and latching. Staff to report any issues to maintenance staff, using the maintenance log located on each nursing unit. IV. The Executive Director/designee will conduct a random audit of 5 doors per week x 4 weeks to determine if doors are closing and latching without impediments. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.	K 521		10/3/21

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K 521	Continued From page 7 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation, fire alarm record review, and interview, the facility failed to ensure that one of one smoke dampers located on one smoke barrier wall for the HVAC (heating, ventilation, and air conditioning) system was maintained in accordance with NFPA 101 (2012 edition) 9.2.1 to NFPA 90A (2012 edition) section 5.4.8.2 to NFPA 105 (2010 edition) 6.5.2 to 6.6.5. This can affect the entire wing including the 100 and 300 halls or a total of 19 residents. Findings include: Observations of the smoke damper at the 100-hall smoke barrier wall near bedrooms 101 on 08/19/21 at 11:20 AM revealed the smoke damper was present on the ventilation duct passing through the smoke barrier wall. Interview with the Assistant Maintenance Director at the time of the observation revealed if maintenance had been completed, it would be in the large binder under fire alarm system. Review of the large fire safety binder revealed a smoke damper maintenance inspection report had not been completed over the past four years. Review of the most recent annual fire alarm inspection dated 04/30/21 revealed no reference to smoke dampers in the report. The code under NFPA 101 (2012 edition) section	K 521	I. Smoke damper inspection is scheduled for 9/29/2021. II. All residents have the potential to be affected. III. Executive Director educated maintenance staff on 9/13/2021 to include smoke damper inspection during annual fire alarm inspection. Contract established with local company on 9/16/2021 to perform test. IV. The Executive Director/designee will report the results of the 9/29/2021 inspection on the next QAPI committee, and at least every 4 years, thereafter to ensure compliance is achieved and maintained.	

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K 521	Continued From page 8 9.2.1 refers smoke damper maintenance to NFPA 90A (2012 edition) section 5.4.8.2. referring to NFPA 105 (2010 edition) section 6.5.2. requiring smoke damper maintenance every "four years." Section 6.5.7. "Requires testing to prove there is no interference", section 6.5.8. that "damper frame has no penetrations of foreign objects that would affect operation", section 6.5.9. that "Damper must be verified it is not blocked," section 6.5.10 "reinstall fusible link after testing, section 6.6.2. that "all exposed moving parts shall be dried lubricated," and section 6.6.5. "That all smoke damper actuation shall be initiated according to the manufacturer with all such actions documented."	K 521		
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		10/3/21

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K 918	Continued From page 9 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, record review, and interview, the facility failed to ensure the transfer switch room contained battery powered emergency lighting in accordance with NFPA 110 (2010 edition) section 7.3.2. This had the potential to affect the safety of all 80 residents. Findings include: Observations of the electrical room on 08/19/21 at 10:25 AM revealed the transfer switch/electrical room lacked emergency battery powered lighting. Interview with the Assistant Maintenance Director at the time of the observation verified the lack of battery lighting in the transfer switch room. The code requires under NFPA 110 (2010 edition) "The level I or level II 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	K 918	I. Battery powered emergency light installed on 9/3/2021 to transfer switch room/electrical room. II. All residents have the potential to be affected. III. The transfer switch room/electrical room is now equipped with battery powered emergency lighting. IV. The Executive Director/designee will audit that lighting to transfer switch is in working condition weekly x 4 weeks. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 30 days to ensure compliance is achieved and maintained.	

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K 918	Continued From page 10 supplied on the load side of the transfer switch."	K 918		

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E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Hawaii, Department of Health on 08/19/21. 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 | 09/17/2021

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.