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	125013	A. BUILDING _____ B. WING _____	10/29/2021

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MAUNALANI NURSING AND REHABILITATION CENTER	5113 MAUNALANI CIRCLE HONOLULU, HI 96816

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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. One Facility Reported Incident (FRI), #8743, from the Aspen Complaints Tracking System (ACTS) was investigated and unsubstantiated. Survey Dates: October 26,2021 to October 29, 2021 Survey Census: 90 Sample Size: 18	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to provide for four residents (R), R11, R240, R242 and R241, an important communication tool to staff, their call light buttons within their reach. This deficient practice robs residents of their independence and could place them into a harmful situation if they are unable to contact staff for immediate assistance. Findings include: 1) On 10/26/21 at 08:47 AM, an initial observation	F 558		

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

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was made of R11 in his room, lying quietly in bed. Surveyor greeted R11 and he sat up in bed, triggering his bed alarm. Certified nursing assistant (CNA)4 entered his room and turned off the bed alarm. Surveyor noted the call light hanging on the wall to the right of R11's bed. Surveyor asked CNA4 if R11 was able to use his call light. CNA4 stated, "Yes, oh my gosh!" as she saw that it was hanging on the wall, out of R11's reach. "Yes, he knows how to use it and it should be closer to him." She placed R11's call light closer to R11.

2) On 10/26/21 at 11:48 AM, surveyor did an initial observation of R240 in her room on the isolation unit. The door to the room was closed. As the surveyor opened the door to R240's room, she observed R240 sitting in her wheelchair, looking uncomfortable with the left footrest of the wheelchair raised and her left leg extended. She stated, "Where were you?! I've been waiting one and half hours for someone. I need to go to the restroom!" Surveyor asked R240 if she could reach her call light to call staff and noted that R240's call light was on her bed not within her reach, approximately one foot away. RN9 assisted R240 to the restroom.

3) On 10/26/21 at 12:20 PM, surveyor did an initial observation with R242 on the isolation unit where the doors to the rooms remained closed. R242 was sitting in her wheelchair with her bedside table raised above her lap. She had a writing pad in front of her. Surveyor communicated via writing to R242 if she can reach her call light that was placed unto her bed, approximately two feet away. She looked at the call light on her bed, attempted to reach for it and stated, "I cannot reach the call light, I use it to call

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for help."

4) On 10/27/21 at 09:45 AM, a follow up observation and interview were conducted with R240 in her room on the isolation unit. R240 was sitting up in her wheelchair with the television on. She was situated approximately a foot away from the call light on her bed. Surveyor asked R240 if she could reach her call light. R240 asked, "Where is my call light?" She was not able to turn to her right to visualize it and made no attempt to reach for it. She further stated, "I sometimes forget." Surveyor asked R240 to recall the incident of the previous day when she wanted to go to the restroom, and she had difficulty remembering. R240 was asked if she waits long for assistance and she stated, "I have to wait a long time, about one hour." Surveyor then asked R240 if she was able to reach her call light and she did not try to unlock her wheelchair to do so. RN9 was asked if R240 was able to reach her call light. He stated that R240 usually knows how to move her wheelchair to reach the call light and moved her wheelchair six inches towards her call light, within her reach.

5) On 10/28/21 at 12:40 PM, surveyor did an observation and interview of R241 in her room on the isolation unit. The speech language pathologist (SLP) had just exited R241's room while surveyor was donning on personal protective equipment (PPE, gown and gloves) to enter the room. R241 was sitting up in her wheelchair eating her lunch. A Japanese program was on the television, and she continued to watch the program while surveyor tried to initiate a conversation. Surveyor observed that R241's call light was buried under the blankets of her bed. R241 was asked if she was able call for staff

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F 558	Continued From page 3 assistance. She looked towards the right where her bed was situated and she motioned with her left hand as if she was holding something in her palm and moved her left thumb up and down, simulating gripping a call light in her hand and pressing the button with her left thumb. She continued to view her program on the television. Surveyor asked Resident Aide (RA)10 if R241 was able to use her call light. She noted that it was buried under R241's blankets and stated, "Oh! The (SLP) was just in here." She uncovered the call light button from under the blanket, pulling up the blankets to the top of R241's pillow. She clipped it to the blanket, approximately seven inches away from her wheelchair, close to R241. She instructed R241 to use her call light for assistance. On 10/29/21 at 09:15 AM, R238 could be heard loudly verbalizing for help through his closed door. On 10/29/21 at 10:00 AM, CNA7 was interviewed in the hallway of the isolation unit. She stated that they check on the residents every two hours.	F 558		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved	F 622		

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sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is

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communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews, the facility failed to provide individualized care for the transfer of one resident, R17, to an acute care

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F 622	Continued From page 6 facility by not providing the receiving facility the resident's comprehensive care plan goals. This deficient practice does not provide an accurate picture of the resident to the receiving facility of the resident's individualized required care and needs and could potentially affect all residents that need extended care at an acute facility. Finding includes: On 10/27/21 at 7:49 PM, copies of R17's EHR were reviewed. Progress notes revealed that she was admitted to the facility on 10/08/21 to receive physical, occupational, and speech therapies. R17 was then transferred to an acute care facility on 10/17/21 for difficulty breathing and fast, irregular heart rate. R17 was re-admitted back to the facility on 10/25/21 with the diagnosis of respiratory failure due to heart failure. On 10/29/21 at 12:12 PM, RN9 was interviewed at the isolation unit's nursing station. RN9 stated that when a resident is transferred to an acute care facility, the facility sends the receiving facility the resident's POLST (Provider Orders for Life-Sustaining Treatment), medication administration record (MAR), face sheet, and transfer sheet. RN9 further stated that the resident's comprehensive care plan is not sent unless the facility requests for it. On 11/01/21 at 08:45 AM, an email request was sent to the Administrator for the facility's policy on resident transfers, but no reply was received.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		

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F 623	Continued From page 7 Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623		

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F 623	Continued From page 8 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility	F 623		

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must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to provide for the proper notification of a facility-initiated transfer of one resident, R17, to the state Ombudsman. This deficient practice denies the added protection of residents who are transferred to an acute care facility as it ensures the Office of the State Long Term Care (LTC) Ombudsman is made aware of facility practices and activities related to facility-initiated transfers and discharges.

Finding includes:

On 10/27/21 at 7:49 PM, copies of R17's EHR were reviewed. Progress notes revealed that she was admitted to the facility on 10/08/21 to receive physical, occupational, and speech therapies. R17 was then transferred to an acute facility on 10/17/21 for shortness of breath and fast, irregular heart rate. R17 was re-admitted back to the facility on 10/25/21 with the diagnosis of respiratory failure due to heart failure.

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F 623	Continued From page 10 On 10/29/21 at 12:12 PM, RN9 was interviewed at the isolation unit's nursing station. RN9 stated that when a resident is transferred to an acute care facility, it is not standard for them to contact the Ombudsman. On 10/29/21 at 1:42 PM, the Assistant Director of Nursing (ADON) was interviewed in the board room. She stated that the Ombudsman is not notified of facility-initiated transfers of residents and is only notified of residents who are discharged to the community. On 11/01/21 at 08:45 AM, an email request was sent to the Administrator for the facility's policy on resident transfers, but no reply was received.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to identify Resident (R)46 had a significant change and was not comprehensively assessed using the CMS-specified Resident	F 637		

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Assessment Instrument (RAI) process within 14 days after the facility should have determined that there was a significant change. Staff were not aware that R46 had a 6.11% weight loss from 09/04/21 to 10/01/21 and as a result, R46 was not comprehensively assessed to address the resident's significant change. As a result of this deficiency, the resident is at a potential risk for harm.

Findings include:

On 10/28/21 at 09:19 AM, conducted a review of R46's Electronic Medical Records (EMR). Review of R46's weights documented on 09/04/21 the resident weighed 188.1 pounds (lbs.) and on 10/01/21, R46 weighed 176.6 lbs., which is a 6.11% weight loss in less than a month. Further review of R46's EMR documented the facility did not start or complete a Minimum Data Set for the resident's significant weight loss within 14 days from 10/01/21, the date the resident had a weight loss greater than 5%. There were no progress notes which documented the facility was aware R46 had a significant weight loss, the care plan was not updated to address the weight loss, and staff documented the resident consistently consumed 100% of meals. There was no assessment completed by the Registered Dietician (RD) that addressed R46's weight loss and/or plan to address the loss. Review of R46's Physician Orders documented an order started on 09/03/21, Dietician may order nutrition supplements. The resident's care plan documented an intervention to monitor the resident's weight and notify the RD if the resident has a greater than 5% change (in weight) in 1 (one) month or less.

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F 637	Continued From page 12 On 10/29/21 at 11:15 AM, conducted a concurrent record review and interview with the Assistant Director of Nursing (ADON). This surveyor inquired with the ADON regarding R46's 6.11% weight loss in less than a month. After reviewing R46's EMR, the ADON confirmed the significant weight loss was not identified by the facility and could not account as to why the resident has had a significant weight loss. The ADON confirmed the resident was not on any medications, there were no documentation of any diagnosis, or physical conditions that would contribute to the resident's 6.11% weight loss. The ADON also confirmed there were no documentation in the EMR indicating the RD was aware of and addressing R46's significant weight loss. The ADON also confirmed a significant change MDS should have been done but was not. On 10/29/21 at 1:13 PM, conducted a telephone interview with the RD. Inquired with the RD if a dietary assessment was completed for R46. RD confirmed a dietary assessment had not been completed for the resident. RD was not aware R46 had a 6.11% weight loss and had not been notified by the facility of the resident's significant weight loss. RD also stated that R46 does have an order to receive nutritional supplements but did not receive any supplements.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and	F 641		

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interviews the facility failed to ensure an assessment accurately reflected the resident's status. Resident (R)23 reported having broken, missing, and loose teeth. Review of the resident's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/01/20, Section L. which documents the resident's oral/dental status documented the resident did not have any fragmented and/or broken teeth. As a result of this deficiency, the resident is at risk for potential negative outcomes related to an inaccurate assessment.

Findings include:

On 10/26/21 at 08:51 AM, during an interview with R23, the resident stated, "I have a lot of teeth in my mouth that are broken or missing and loose. It is annoying as it causes me to spit a lot." Surveyor's observation of R23 oral cavity confirmed that R23 has broken and missing teeth.

On 10/28/21 at 12:30 PM, a record review was conducted and documented R23's Annual MDS with an ARD of 11/01/20, Section L. documents the resident's oral and dental status. L0200 was coded as "None of the above present" documenting R23 did not have "B...tooth fragment(s)" or "D...broken natural teeth" which contradicted the resident's statement. Review of two (2) quarterly MDS with ARDs of 05/03/21 and 08/03/21, Section L was not answered.

On 10/29/2021 at 11:00 AM, conducted an interview with the MDS Coordinator. The MDS Coordinator stated he/she did not complete the Annual MDS with an ARD of 11/01/20 for R23. MDS Coordinator stated the Unit Manager was

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F 641	Continued From page 14 the person of contact for R23's MDS. On 10/29/21 at 11:39 AM, conducted a concurrent interview and record review with Unit Manager (UM) 2 at the resident's bedside. UM 2 performed a visual and tactile inspection of R23's oral cavity. UM2 confirmed R23 has broken natural tooth on the lower left side of resident's mouth. UM 2 reviewed R23's annual MDS with an ARD of 11/01/20, Section L Oral/Dental and confirmed it was not accurate for R23.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655		

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F 655	Continued From page 15 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that the baseline care plan for one resident, R238, was updated to address non-pharmacological interventions to manage his pain. This deficient practice failed to provide R238 with an individualized care approach for his pain, which could result in unrelieved pain and potentially negative psychosocial outcomes. Findings include: On 10/26/21 at 11:42 AM, an initial observation of R238 was done in his room on the isolation unit. R238 was wearing a neck brace restricting movement of his head and neck as he lay stiffly in his bed. He complained of pain to his neck and shoulders. The SLP was in his room to assess his swallowing.	F 655		

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On 10/27/21 at 09:09 AM, a follow up observation and interview with R238 was done in his room. R238 lay stiffly in bed and was grimacing, complained of his shoulders being sore. His right eye was swollen and there was a bruise on his forehead with a small, healing cut. R238 stated that he sustained his injuries from falling unto his head. He verbalized the current date and time and the place where he was residing. The interview could not be continued due to distractions caused by a contracted worker in his room fixing the call light. RN9 informed surveyor that the physician for R238 ordered an additional pain medication.

On 10/27/21 at 6:15 PM, copies of R238's EHR were reviewed. Progress notes revealed that R238 was admitted to the facility on 10/21/21 for physical, occupational and speech therapies with the diagnosis of central cord syndrome (nerve impulse conduction is reduced) due to cervical (neck) spinal cord injury. His care plan goal, "I will be comfortable with current pain regimen through next review date" did not include non-medication pain management for R238's neck and shoulder pain.

On 10/29/21 at 09:47 AM, RN9 was interviewed at the isolation unit's nursing station. RN9 stated that he used alternative pain management techniques for R238 which helped with his pain, like deep breathing, massage, listening to music and watching television. RN9 further stated that the pain management methods he used that work for R238 should be incorporated into his care plan.

On 10/29/21 at 1:00 PM, the facility's policy on

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F 655	Continued From page 17 Pain, "Date: 01/266(sic)/2021 rev" was reviewed. "Definition: ...F. Consider non pharmacologic interventions to alleviate pain... I. Care plan pain and interventions considering the resident's goal and preferences."	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		

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F 656	Continued From page 18 (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 observations, staff interviews, and record review, the facility failed to ensure a comprehensive person-center care plan was implemented for 1 of 18 (Resident (R)46) residents sampled. R46's care plan documented the Registered Dietician (RD) should be notified if the resident has a greater than 5% weight loss in one month or less and staff should play Hawaiian CD's when the resident is in the room for sensory stimulation. R46 had a 6.11% weight loss in less than a month and the RD was not notified, and Hawaiian music was not played when the resident was in the room. As a result of this deficient practice, the resident is at risk of potential physical and psychosocial harm. Findings include: 1) On 10/28/21 at 09:19 AM, conducted a review of R46's Electronic Medical Records (EMR). Review of the resident's care plan (CP) documented R46 is at risk for inadequate energy intake related to physiological cases with an intervention to monitor the resident's weight and notify the RD if the resident has a greater than 5% change (in weight) in 1 (one) month or less. Review of R46's weights documented on	F 656		

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09/04/21 the resident weighed 188.1 pounds (lbs.) and on 10/01/21, R46 weighed 176.6 lbs., which is a 6.11% weight loss in less than a month.

On 10/29/21 at 11:15 AM, conducted a concurrent record review and interview with the Assistant Director of Nursing (ADON) regarding R46's significant weight loss. The ADON navigated R46's chart and confirmed R46 did have a 6.11% weight loss from 09/04/21 to 10/01/21. Inquired with the ADON if the facility notified the RD of R46's greater than 5% weight loss in less than a month. The ADON navigated R46's EMR and confirmed the facility did not notify the RD of R46's greater than 5% weight loss.

On 10/29/21 at 1:13 PM, conducted an interview with the RD. The RD confirmed the facility did not notify him/her that R46 had a greater than 5% change in weight in a month or less.

2) Multiple observations (10/26/21 at 10:48 AM, 11:02 AM, 11:53 AM, 12:23 AM, 1:30 PM, and 3:00 PM; 10/27/21 at 09:03 AM, 10:15 AM, 11:05 AM, 12:15 PM, and 1:45 PM; 10/28/21 at 09:12 AM, 11:25 AM to 1:30 PM (continuously); and 10/29/21 from 06:40 AM to 08:36 AM (continuously) and 10:30 AM) were made of R46 in the room with no Hawaiian music playing. A radio with a CD player and CDs were observed on the resident's bedside dresser. On three separate days, (10/27/21 at 1:45 PM, 10/28/21 at 1:30 PM, and 10/29/21 at 10:30 AM) inquired with the resident staff played Hawaiian music or any music for the resident that day. The resident responded "No" each day the resident was questioned.

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F 656	Continued From page 20 On 10/28/21 at 09:19 AM, conducted a review of R46's Electronic Medical Records (EMR). Review of the resident's CP documented listening to Hawaiian music lifts R46's spirit up and activities had provided a radio with a CD player, Hawaiian CDs to listen to, and to play the Hawaiian CD's when the resident is in the room as an intervention to a goal to maintain R46's sensory stimulation to maintain the resident's current level of functioning through the next review. On 10/29/21 at 08:13 AM, reviewed R46's Activity Kardex. The Activity Kardex documented R46 did not participate in any activities while in the facility. On 10/29/21 at 11:20 AM, conducted a concurrent record review and interview with the Assistant Director of Nursing (ADON) regarding R46's CP for sensory stimulation. Shared observations of R46 in the room, awake with no music playing and no other form of sensory stimulation for the resident. The ADON confirmed staff should have been playing Hawaiian music for the resident.	F 656		
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.	F 657		

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(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).
An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to update the care plans of two residents, R7 and R46, out of 18 sampled residents. This deficient practice is a neglect of the interdisciplinary team (IDT) to recognize the needs and care of these residents and could potentially affect all residents.

Findings include:

1) On 10/26/21 at 10:06 AM, observed R66 in assigned room grimacing in pain and asking staff to assist with changing positions to relieve the resident's back pain. Certified Nurse Aide (CNA)45 and CNA98 assisted R66 with the position change the resident grimaced and yelled out in pain. Inquired with the resident regarding the resident's non-verbal indicators of pain (grabbing lower lack, grimacing, frowning, and closing his/her eyes). R66 stated that he/she had

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fallen about a month ago and has had pain back that started post-fall. The resident explained that his/her back pain in unrelieved and staff just offer the resident pain medications to treat the pain. R66 denied staff use a warm compress.

On 10/26/21 at 12:14 PM, conducted a review of R66's Electronic Medical Record (EMR). On 09/21/21 at approximately 11:40 AM, Resident (R)66 had an unwitnessed fall in the bathroom and complained of pain to the lower back and midback with movement. After the fall and x-ray the resident was diagnosed with pain due to assisted fall. A review of R66's care plan did not document the implementation of non-pharmacological interventions to address the resident's back pain related to the fall on 09/21/21. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not document non-pharmacological interventions.

On 10/29/21 at 10:19 AM, conducted a concurrent interview and record review with the Assistant Director of Nursing (ADON). ADON reviewed R66's care plan and confirmed non-pharmacological interventions were not included in the resident's care plan and should have been included.

2) On 10/28/21 at 2:20 PM, R7 was interviewed in the unit's dining room. Surveyor informed R7 that multiple attempts were made to see him on 10/26/21 and 10/27/21. R7 stated that he was not in the facility on 10/26/21 because he had an "extra treatment" at dialysis to remove excess fluid and he was out on 10/27/21 again for his regular three times a week hemodialysis session. R7 sat in his wheelchair during the interview and

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the skin on his lower legs appeared shiny, taut, and darkened in color. He spoke in a soft voice, occasionally catching his breath. He stated that he doesn't drink much and doesn't know how he had gained a lot of fluid.

On 10/29/21 at 08:16 AM, R7's EHR was reviewed. His weight on 09/02/21 was 178.6 pounds and on 10/08/21 it was 185.6 pounds. Under "Nutritional/Dietary Notes" dated 10/03/21 and timed 19:39 (7:39 PM), revealed that R7's preferred weight was 180 pounds and he agreed to change his weight goal to be between 175 and 185 pounds.
"Nutritional/Dietary Notes" written on 10/27/21 at 10:49 AM, stated " ...weight fluctuations d/t (due to) frequent excess fluids and hx (history) noncompliance with diet, resident is aware of diet restrictions and has received multiple nutrition education re: complying with diet ...Will refer to RD (registered dietitian) to review."
R7's care plan did not address R7's needed care and interventions for his increased fluid gain, other than education, which was not effective, causing R7 to require an extra dialysis treatment to remove excess fluids.

On 10/29/21 at 09:31 AM, paper copies of R7's dialysis communication records were reviewed. A handwritten communication to the facility on 10/13/21 from the hemodialysis (HD) nurse stated, "Pls. reinforce fluid restrictions, Pt. (patient) is coming in > (greater than) 5 (five) kg (kilograms) wt. (weight) gain (equaling to 11 pounds)."

On 10/29/21 at 1:15 PM, the facility's policy on Care Plan, "Date: 02/10/21 rev" was reviewed. " ...4. Care plans will include: ...b. Identified

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F 657	Continued From page 24 problem areas, including risk factors or barriers that may affect goals."	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide an ongoing program to support residents in their choice and preferences of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of 1 resident out of 6 in the sample. Findings include: Record review on 10/27/21 at 09:00 AM, documented a 99-year-old alert male was admitted on 08/23/21 for status post fall with left humerus fracture (without surgery). Observation was made on 10/27/21 at 09:23 AM of resident (R)45. R45 would not wake up to his name. At11:00 AM, R45 sleeping and still in bed. Interview with clinical nurse's aide (CNA)2 who	F 679		

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	125013	A. BUILDING _____ B. WING _____	10/29/2021

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MAUNALANI NURSING AND REHABILITATION CENTER	5113 MAUNALANI CIRCLE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 25	F 679		

stated, "he is always like that."

Record review (RR) on 10/27/21, documented no activity was recorded for R45 on 10/27/21 in the electronic medical record under tasks.

On 10/28/21 at 08:15, R45 was sleeping and would not get up. At 08:50 AM, the resident was sleeping and remained in bed for the morning.

Interview with Director of Community life (DCL) was done on 10/28/21 at 12:30 PM. DCL explained that our goal for activities is that the residents are out of their room. The CNAs on the floor engage them in activities. It could be something small like watching TV or getting the newspaper. Whomever does not come out of their rooms or engage in activities, we will go do visits in the room. DCL stated this is documented in the chart under tasks.

Observation on 10/28/21 at 12:57 PM of R45 reveals resident sleeping in bed, laying down and TV on.

RR showed no activity was recorded for R45 on 10/28/21 in the electronic medical record under tasks.

Observation of R45 on 10/29/21 with CNA3 was done on 10/29/21 at 8:45 AM. R45 was awake and being assisted with his breakfast meal in bed. Queried CNA3 why R45 has not been out of bed this week. CNA3 was not able to give a definite answer.

RR on 10/29/21 Record did not show any activity for the month of October except on 10/29/21 where group activities was checked off for 12:06

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F 679	Continued From page 26 PM under the tasks bar. R45 is care-planned for activity interests and preferences such as playing word games such as scrabble on the phone, joining Veteran's Programs and Events if invited, reading sports news on magazines and the newspaper if offered to me. These activities were not witnessed during this survey.	F 679		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide the necessary care for R7's retention of excess fluids and proper care of his hemodialysis catheter by not utilizing open communication with the dialysis facility personnel and by not having appropriate policy and procedures in place. These deficient practices is a neglect of the specialized needs and care of residents requiring dialysis to live. Findings include: On 10/28/21 at 2:20 PM, R7 was interviewed in the unit's dining room. Informed R7 that surveyor made multiple attempts to see him on 10/26/21 and 10/27/21. R7 stated that he was not in the facility on 10/26/21 because he had an "extra treatment" at dialysis to remove excess fluid and again on 10/27/21 for his regular three times a week hemodialysis session. R7 sat in his	F 698		

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wheelchair during the interview and the skin on his lower legs appeared shiny, taut, and darkened in color. He occasionally needed to catch his breath during the interview. He stated that he doesn't drink much and doesn't know how he had gained a lot of fluid. Surveyor noted a white adherent dressing to R7's right upper chest. He stated that he has a permanent dialysis catheter to his right upper chest because of difficulties in creating a permanent dialysis access in his arms. R7 states that he is able to shower, but the dialysis catheter dressing needs to be covered with plastic to ensure that it does not become wet. He stated that it became wet after a shower once and the staff used a blow dryer to dry off the dressing. R7 was asked if the staff called the dialysis center to ask what to do with a wet catheter dressing, but he stated that the dialysis facility was not contacted and staff continued to blow dry the dressing until it became dry.

On 10/29/21 at 08:16 AM, R7's EHR was reviewed. His weight on 09/02/21 was 178.6 pounds and on 10/08/21 it was 185.6 pounds. "Nutritional/Dietary Notes" dated 10/03/21 and timed 19:39 (7:39 PM), revealed that R7's preferred weight is 180 pounds and he agreed to change his weight goal to be between 175 and 185 pounds.
"Nutritional/Dietary Notes" written on 10/27/21 at 10:49 AM, stated " ...weight fluctuations d/t (due to) frequent excess fluids and hx (history) noncompliance with diet, resident is aware of diet restrictions and has received multiple nutrition education re: complying with diet ...Will refer to RD (registered dietitian) to review."
R7's care plan did not address R7's needed care and interventions for his increased fluid gain, other than education, which was not effective,

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causing R7 to need an extra dialysis treatment to remove excess fluids. R7's care plan also stated "Staff may cover the permacath (permanent dialysis catheter) site on right chest with plastic prior to shower. Keep area dry at all times." It did not address the intervention(s) to take if R7's dialysis catheter dressing becomes accidentally wet with his shower. R7's care plan also stated, "May contact (outpatient dialysis center and phone number) for dialysis related concern."

On 10/29/21 at 08:00 AM, a request for the facility's dialysis catheter dressing policy and procedure (P&P) was made to the DON.

On 10/29/21 at 09:31 AM, paper copies of R7's dialysis communication records were reviewed. A handwritten communication to the facility on 10/13/21 from the hemodialysis (HD) nurse stated, "Pls. reinforce fluid restrictions, Pt. (patient) is coming in > (greater than) 5 (five) kg (kilograms) wt. (weight) gain" (equaling to 11 pounds).

On 10/29/21 at 09:47 AM, RN9 was queried about the process the facility uses if a permanent dialysis catheter dressing becomes wet and he stated that he would need to look at the facility's policy.

On 10/29/21 at 11:17 AM, the registered dietitian (RD) was interviewed via telephone. His management of a dialysis resident who has trouble maintaining their fluid restriction is to educate them and he consults with the dietitian at the dialysis facility only if there any concerns with the resident's lab results.

On 10/29/21 at 1:42 PM, a follow up query was

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F 698	Continued From page 29 made with the ADON and she was asked about the dialysis catheter dressing policy and procedure. She stated that it mentioned only to keep the dressing dry. A copy of the policy and procedure was not given to the surveyor.	F 698		
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 observation, interviews and record review, the facility failed to prepare, distribute, and serve food in accordance with professional standards for food service safety during dining service. Findings include: On 10/26/21 at 11:41 AM, the dining cart arrived	F 812		

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F 812	Continued From page 30 and was parked on the third floor. Meals were prepped by all staff at the nursing station and then brought to residents' rooms. Observation to Room 318 by staff carrying the tray from nursing station without hand sanitization going in. Delivery to Room 316 without hand sanitization coming out of room. At 11:51 AM on 10/20/21, another staff went into deliver a tray to 318 without hand sanitization (HS) going in and no HS coming out. Tray delivery to Room 301 showed no HS going in and no HS coming out of Room 301. Interview with Registered Nurse (RN)1 who stated she was the charge nurse was done. RN1 stated that the protocol is to HS before going in because you have been touching a lot of stuff, after patient care and in between. Further observation done on 10/28/21 at 12:17 PM where surveyor observed Unit manager (UM)1 and Certified Nurse Aide (CNA)4 passing trays with no HS before going into the room. Record Review on 10/28/21 at 02:00 PM of Policy No. N-62 Handwashing/Sanitizing, page 7 "when to sanitize hands" states that staff should sanitize hands " 1) Before entering and upon leaving residents rooms. 2) Before and after handling food.	F 812		
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	F 880		

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews and record review, the facility failed to prepare, distribute, and serve food in accordance with professional standards for food service safety during dining service.

Findings include:

On 10/26/21 at 11:41 AM, the dining cart arrived and was parked on the third floor. Meals were prepped by all staff at the nursing station and then brought to residents' rooms. Observation to Room 318 by staff carrying the tray from nursing station without hand sanitization going in. Delivery to Room 316 without hand sanitization coming out of room. At 11:51 AM on 10/20/21,

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F 880	Continued From page 33 another staff went into deliver a tray to 318 without hand sanitization (HS) going in and no HS coming out. Tray delivery to Room 301 showed no HS going in and no HS coming out of Room 301. Interview with Registered Nurse (RN)1 who stated she was the charge nurse was done. RN1 stated that the protocol is to HS before going in because you have been touching a lot of stuff, after patient care and in between. Further observation done on 10/28/21 at 12:17 PM where surveyor observed Unit manager (UM)1 and Certified Nurse Aide (CNA)4 passing trays with no HS before going into the room. Record Review on 10/28/21 at 02:00 PM of Policy No. N-62 Handwashing/Sanitizing, page 7 "when to sanitize hands" states that staff should sanitize hands " 1) Before entering and upon leaving residents rooms. 2) Before and after handling food.	F 880		

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E 000	Initial Comments A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on 10/26/21 to 10/29/21. The facility met the requirements for Appendix Z, Emergency Preparedness, §42 CFR 483.73 for long term care facilities.	E 000		

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

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 531 SS=D	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: K-531 Elevators This STANDARD is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for an annual inspection for the facility's elevators in accordance with NFPA 101, Life Safety Code, 2012 edition, section 9.4.6.1. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of an annual inspection to ensure proper fire fighter operations. Findings include: During record review on 11/2/21 at approximately 1:15 pm revealed that the facility failed to provide documentation for the annual elevator inspection.	K 531		

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K 531	Continued From page 1 These findings were verified at the exit conference with the facility manager and Administrator on 11/2/21 at 2:20 pm.	K 531		
K 761 SS=E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: K-761 Maintenance, Inspection, and testing-Doors This STANDARD is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for an annual inspection for the fire doors in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, sections 5.2, and 5.2.3. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of an annual inspection to ensure proper protection from fire and smoke extension within the facility. Findings include: During record review on 11/2/21 at approximately	K 761		

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K 761	Continued From page 2 1:15 pm revealed that the facility failed to provide documentation for the annual fire door inspection. These findings were verified at the exit conference with the facility manager and Administrator on 11/2/21 at 2:20 pm.	K 761		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUNALANI NURSING AND REHABILITATION CENTER	**5113 MAUNALANI CIRCLE** **HONOLULU, HI 96816**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 3 cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: K-923 Gas Equipment-Other This STANDARD is not met as evidenced by: Based on observation and staff interview with maintenance staff, the facility failed to provide adequate separation and proper signage for full and empty "E" oxygen cylinders in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, sections 11.6.5.2, and 11.6.5.3. This deficiency could affect all residents requiring oxygen therapy by the possibility of administering an empty oxygen cylinder in lieu of a full cylinder during an emergency. Findings include: During facility survey on 11/2/21 at approximately 1:45 pm, revealed that the facility failed to provide adequate separation and proper signage in the oxygen storage room. These findings were verified at the exit conference with the facility manager and Administrator on 11/2/21 at 2:20 pm.	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. BUILDING _____ B. WING _____	11/02/2021

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E 000	Initial Comments THIS FACILITY MET THE LIFE SAFETY REQUIREMENTS OF APPENDIX "Z"; IN ACCORDANCE WITH CFR 483.73, REQUIREMENT FOR LONG-TERM CARE (LTC) FACILITIES	E 000		

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

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