STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125063	A. BUILDING _____ B. WING _____	10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
15 CRAIGSIDE	**15 CRAIGSIDE PLACE HONOLULU, HI 96817**

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) from 10/26/21 through 10/29/21. The facility was found to be in substantial compliance with 42 CFR 483 Subpart B. A facility reported incident (ACTS #8466) was also investigated during the recertification survey. There was no citation related to the investigation of the facility reported incident. Survey Census: 36 Sample Size: 14	F 000		

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

Electronically Signed | 11/03/2021

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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E 000	Initial Comments A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) from 10/26/21 through 10/29/21. The facility was found to be in substantial compliance with Appendix Z, Emergency Preparedness, §42 CFR 483.73 for Long Term Care facilities.	E 000		

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	125063	A. BUILDING **01 - 15 CRAIGSIDE** B. WING _____	**11/18/2021**

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K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and staff interview with the maintenance director and Administrator, the facility failed to ensure that the hazardous area door for biohazard waste was equipped with a self-closing device. This observation of the missing door self-closing device is not in accordance with the 2012 edition of the NFPA 101 Life Safety Code, section 7.2.1.8.1. This deficient practice could affect all residents, staff, and visitors if smoke and fire was to move from these areas into the exit corridor. Findings include: An observation on 11/18/21 at approximately 12:00 pm revealed the biohazard waste storage room was not equipped with a self-closing device. These findings were verified at the exit conference with the maintenance director and Administrator on 11/18/21 at 1:00 pm.	K 223	15 Craigside is committed to ensuring that residents remain safe and attain or maintain the highest practicable quality of life. On 11/24/21, Environmental Services Manager (ESM) and Administrator (NHA) confirmed that the Self-Closing device for the biohazard waste door was installed and operating correctly. Please see attachment A. On 11/24/21, ESM and NHA confirmed that all 2nd floor resident doors, exit doors, stairway doors and biohazard door are equipped with a self-closing device. On 11/24/21, ESM and NHA added the inspection of self-closing devices for 2nd floor resident doors, exit doors, stairway	12/1/21

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K 223	Continued From page 1	K 223	doors and biohazard door to the monthly inspection report. Please see attachment B (Page 10). Effective 11/24/21, ongoing monitoring of the self-closing devices in identified areas will completed through in-house monthly inspections. Findings from the monthly inspections will be reviewed and shared during the facilities quality assurance meeting.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than 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	K 363		12/1/21

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K 363	Continued From page 2 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: This standard is not met as evidenced by: Based on observation and staff interview with the maintenance director and Administrator, numerous fire doors located throughout the facility did not have rating labels on door frames in a legible condition in accordance with NFPA 101, Life Safety Code, 2012 edition, section 8.3.3.2.3. This deficiency would not affect patients, staff, and visitors during a fire because the labeling does not affect the performance of the fire door. Findings include: An observation on 11/18/21 at approximately 12:15 pm revealed that numerous fire door labels on door frames were covered with paint and unable to read the fire door frame rating. This finding was verified at the exit conference with the Administration and facility manager on 11/18/21 at 1:15 pm.	K 363	15 Craigside is committed to ensuring that residents remain safe and attain or maintain the highest practicable quality of life. On 11/24/20212, ESM identified all affected fire doors and developed a plan to ensure that the rating labels on the fire doors would be legible. Targeted date for the completion of each identified fire door is week of 12/1/2021. Please see attachment C for repaired label on fire doors. As of 12/1/2021, Environmental Services Department (ESD) has confirmed all rating labels on fire doors on the 2nd floor are legible. Effective 1/1/2022, ESD will complete audits on fire doors throughout the facility on a monthly basis to ensure rating labels are legible. See attachment B (Pages 2 and 4) for audit. Effective 1/1/2022, ESD will complete	

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K 363	Continued From page 3	K 363	audits on fire doors throughout the 2nd floor on a monthly basis to ensure rating labels are legible. In addition, on an annual basis, all fire doors will be inspected to ensure rating labels are legible. See attachment D and Fire Door Inspection Criteria for completing annual door checks form. Effective 1/1/2022, ESD will complete audits on fire doors throughout the 2nd floor on a monthly basis to ensure rating labels are legible. On an annual basis, all fire doors will be inspected to ensure rating labels are legible. Findings from the monthly and annual audits/inspections will be reviewed and shared during the facilities quality assurance meeting.	
K 918 SS=D	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	K 918		12/1/21

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K 918	Continued From page 4 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: This STANDARD is not met as evidenced by: Based on record review and staff interview with facility manager and Administrator, the facility failed to produce documentation for an annual testing of diesel fuel in accordance with NFPA 99 Healthcare Facilities Code, 2012 edition, section 6.5.4, and NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition, section 8.3.8. This deficiency could affect all residents, staff, and visitors during an interruption of grid power due to the lack of an annual diesel fuel test to ensure proper operation of the standby power system. Findings include: An observation during record review on 11/18/21 at approximately 11:15 am revealed that the vendor conducting both generator testing and diesel fuel leak detection did not conduct an annual fuel quality test. This finding was verified at the exit conference with the Administration and	K 918	15 Craigside is committed to ensuring that residents remain safe and attain or maintain the highest practicable quality of life. On 11/18/2021, ESM contacted the vendor responsible for the generator testing and confirmed a date of 11/19/201 to have the fuel quality tested. Fuel quality test report is estimated to be completed and sent by vendor on 12/17/2021. Please see Attachment E for email correspondence. Effective 11/18/2021, contracted vendor will complete an annual inspection of the fuel quality and submit the report to the ESM. Effective 11/18/2021, contracted vendor	

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K 918	Continued From page 5 facility manager on 11/18/21 at 1:15 pm.	K 918	will complete an annual inspection of the fuel quality and submit the report to the ESM. The annual report will also be reviewed and noted during that quarters Quality Assurance meeting.	

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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		

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