STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125047	A. BUILDING _____ B. WING _____	01/28/2022

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HALE OLA KINO	1314 KALAKAUA AVENUE, 2ND FLOOR HONOLULU, HI 96826

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA). The facility was not in compliance with 42 CFR 483 Subpart B. Survey Dates: 01/25/22 to 01/28/22 Survey Census: 31 Sample Size: 22	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F 578		3/21/22

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

Electronically Signed | 02/21/2022

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F 578	Continued From page 1 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, review of policy on Advance Health Care Directives (AHCD), and review of Resident Rights, the facility failed to ensure that a physician's code status order was consistent with Resident (R) 125's wish to not receive Cardiopulmonary Resuscitation (CPR). As a result of this deficient practice, there was the potential for R125 to receive CPR in the event of an "emergency" which was in direct conflict with the wish to not receive CPR. Findings include: Review of the Electronic Health Record (EHR) showed R125 was admitted on 01/07/22 with a diagnosis of Cervical Spinal Stenosis, Benign Paroxysmal Vertigo, Dementia, Diabetes Mellitus Type 2, Vitamin D Deficiency, Hypertension, Gastroesophageal Reflux, Insomnia, Malignant Neoplasm of Breast. A review of R125's AHCD regarding end-of-life matters showed the following choice; to not	F 578	1.Upon learning of the deficient practice, the resident's wishes related to advance directives have been reviewed and the health record has been updated to reflect the resident preferences. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. All resident records have been reviewed to validate that the resident's physician orders and POLST reflect the resident's current preferences. 3.What measures will be put into place (or changes) to ensure that the deficient practice will not recur. The interdisciplinary team (IDT) has been re-educated regarding the resident□s right to enact advance directives and documentation requirements. The social worker assists each resident and/or resident representative to formulate	

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F 578	Continued From page 2 prolong life if the situation is hopeless. Another form titled Provider Orders for Life-Sustaining Treatment (POLST) also showed the choice; Do Not Attempt Resuscitation (DNAR). However, upon review of the EHR for R125, there was a doctor's order of "Full Code" which meant that CPR was ordered in the event of an "emergency". According to R125's AHCD and POLST documents, this was not what R125 wanted. On 01/28/22 at 11:00 AM, the Director of Nursing (DON) was queried about the conflicting order. DON verified with the doctor and acknowledged that the doctor's order was wrong and should have followed R125's wish not to be resuscitated. DON stated that they will immediately make the necessary correction. A review of facility policy on AHCD stated the following: Purpose, supports a resident's right to participate in health care decision making. Through education and inquiry about advance health care directives, this facility will encourage residents to communicate their health care preferences and values. Social Services will assist the resident and/or responsible party to understand the options available. Policy, it is the policy of this facility that 1. Prior to or upon admission of a resident, the Resident Care Manager or Social Service Director will ask residents, and/or their family members, about the existence of any advance health care directives. 2. Should the resident indicate that he or she has issued advanced health care directives about his or her care and treatment, the facility will require that a copy of such directives be included in the medical record, and the facility will confirm that directives are current and still the desires of the resident ... 8. The facility shall comply with the	F 578	advance directives regarding end-of-life matters upon admission. A resident□s care plan which includes advance directives, physician orders and POLST, is reviewed and/or updated by the IDT on a quarterly basis, or when the residents expressed preferences may change. 4. How will the facility monitor its corrective action to ensure it doesn□t recur? The social worker will continue to interview residents and/or resident representatives on admission to formulate advance directives. The medical records coordinator will audit admission records to validate that the resident□s advance directives are documented in the physician orders and POLST. The medical records coordinator will track admission audit findings and submits monthly reports to the QAA Committee for further review and recommendations.	

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F 578	Continued From page 3 written or oral declarations of a resident, or the treatment decision of his or her surrogate. If the resident's attending physician refuses to comply with the lawful declaration of the resident, or the lawful treatment decisions of his or her surrogate, the facility will assist the resident or resident's surrogate in obtaining another attending physician who is willing to carry out the wishes of the resident, or transfer the resident to another facility. 11. This facility will notify the physician of advance health care directives so that appropriate orders can be documented in the resident's medical record. 14. Inquiries concerning advance health care directives should be referred to the administrator, the resident care manager, or the social service director. A review of the Statement of Resident Rights stated the following: Resident Rights, the resident has a right to a dignified existence, is treated with respect and dignity, and receives care in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life. The facility must protect and promote the rights of each resident ... Self-Determination, the facility must promote and facilitate resident self-determination through support of resident choice in various aspects of life in the facility.	F 578		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 725		3/21/22

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F 725	Continued From page 4 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations. Interviews and record reviews, the facility failed to provide timely toileting needs for Resident (R) 15. This deficient practice has the potential to affect other residents who require toileting needs and has a risk for Urinary Tract infections (UTI). Findings include: Record review (RR) done on 01/26/22 at 2:58 PM shows R15 was prescribed doxycycline 100 mg tablets on 11/22/21 for a UTI. Observation on 01/27/22 at 07:15 AM of R15 in her room sleeping. Pillow tucked to right side, off loaded to the left with pillows under her knees.	F 725	1.Upon learning of deficient practice, what corrective action was done. -Immediate coaching and re-education provided to the 2 CNAs who were in the room at 8:42am for what could have been an anticipated toileting opportunity for the resident which could have shortened the resident'□s wait time. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. -A list was generated of all residents with a care plan requiring anticipation of toileting needs. Residents who scored 9 or less in the Bowel and Bladder Assessment who are considered poor	

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F 725	Continued From page 5 Observation on 01/27/22 at 0758 AM, still lying-in bed, same position as 07:15 AM. Observation on 01/27/22 at 08:42 AM, R15's breakfast arrived. She was pulled up with two nurse's assistants. Observation on 01/27/22 at 09:00 AM and a concurrent interview with certified nursing assistant (CNA)2 was done. Query with CNA2 regarding intake of breakfast was made. CNA2 stated that she had poor intake and fluids were 40 ml and she ate 20% of her meal. Observation of the R15 reveals that the resident appeared uncomfortable and is making a noticeable moaning sound. Observation on 01/27/22 at 09:50 AM revealed that R15's brief had not been changed yet. Observation on 01/27/22 at 10:00 AM, CNA2 came into the room. R15 demonstrating distress with increased moaning, louder than earlier and at a quicker pace. This surveyor queried with CNA2 if R15 had any problems with breathing and why is she making a loud moaning sound? Does she need to go shi shi (urinate) and R15 responded clearly "shi shi"to surveyor and CNA. R15 continued to moan loudly. As CNA2 began to get R15 up, she continued to moan louder. R15 was taken to the restroom by wheelchair. CNA2 stated that she hardly goes in her diaper, she goes in the toilet. R15 immediately urinated when seated on the toilet. R15 stopped moaning after urinating. She was able to sigh in relief as she looked at surveyor. At that time, CNA1 arrived. Upon query with CNA1, who stated that	F 725	candidates to receive bladder training. -Re-Educated all staff at an awareness meeting on all shifts addressing anticipation of toileting needs of all residents on the list. 3. What measures will be put into place (or changes) to ensure that the deficient practice will not recur. -Morning rounds, including toileting program during the busy hours of meals service was reviewed, organized, and restructured increasing planned opportunities to toileting residents while staff are already in the room serving in-room dining. Nurses will be re-educated to identify needs through observation and offer toileting as needed during in-room visits. 4. How will the facility monitor its corrective action to ensure it doesn□t recur? -All nurses will be re-trained on the anticipation of toileting need revised program by March 1, 2022. -Random floor observation will be conducted by nurse managers daily for 3 months. -ADL audits on toileting will also be done on target residents weekly for 3 months by the QA nurse.	

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F 725	Continued From page 6	F 725		

resident was taken to the restroom at the last time of 6:30 this AM, 3.5 hours ago. CNA2 showed surveyor that the brief was dry.

RR shows resident's care plan for alteration in skin integrity with interventions of "anticipate toileting needs - keep resident dry." Care plan for at risk for infection, interventions include monitor for urgency and frequency of urination; monitor for abdominal pain or discomfort, foul smelly urine, decreased urine output, fever, bloody urine, concentrated urine output.

Interview on 01/27/22 at 12:36 PM Registered Nurse (RN)1, was performed. RN1 was asked how they train their staff regarding a bladder program? RN1 stated that we just tell the CNAS that the resident is on a bladder training program.

In an interview with the Director of Nursing (DON) on 01/27/22 at 1:00 PM, the DON was queried regarding a bladder program guidelines or protocol. DON stated that "there is a general rule for our CNAs to document. When the residents come, we don't know if the residents are continent or incontinent. We identify their pattern. When we identify their pattern, we train them in that pattern. We do not have any guidelines that say every two hours or a time-based guideline.

Observation was shared with the DON regarding toileting of R15. DON stated that she created the morning routine for the nurses' aides. Breakfast rounds is at 07:15 AM. Everyone does their rounds and takes care of their own toileting from first rounds. At 7:15 AM, everyone does the dining, and we serve as able. There is a runner for A side. C side distributes the meals in the rooms simultaneously. After dining is done, we

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F 725	Continued From page 7 are all facing a one to one. Although the nursing assignment shows CNA1 assigned to R15's room (212A); CNA1 was also assigned to the dining room at breakfast rounds said the DON. This surveyor queried the DON regarding what urgency means - DON stated that it means they can call when they want to go to the bathroom. The DON confirmed that R15 could not use the call bell. R15 waited 3.5 hours to use the toilet and was moaning in distress and could not use the call bell. DON concluded that an assessment for an adaptive call bell for R15 would be initiated.	F 725		
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, staff interview and review	F 812	For purposes of this F812, the staff	3/11/22

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F 812	Continued From page 8 of policy, the facility failed to label three food containers and properly store eighteen (18) tomatoes that was in the refrigerator located outside the unit's food pantry. Findings include: On 01/25/22 at 09:40 AM, during an observation of the refrigerator located outside the unit's food pantry, three food containers which contained fruits, rice, and meats were not labeled with dates. Also, 18 tomatoes were noted on the top shelf of the door and was open to air and not in any container. A sign was posted on the refrigerator door which stated the following: Stop, attention all families and residents, is your food labeled and dated? All food that is not properly labeled and dated will be thrown away! All food more than 3 days old will be thrown away. On 01/25/22 at 10:00 AM, the Administrator (Admin) was queried about the observations as previously mentioned. Admin stated that the refrigerator was used for food that was brought (from outside the facility) for the residents. Admin acknowledged that the three food containers and the 18 tomatoes should have been properly labeled and/or properly stored. Admin proceeded and immediately removed the three containers and tomatoes from the refrigerator. A review of the facility policy on Use and Storage of Food and Beverage stated: Policy, it is the policy of this community to provide safe and sanitary storage, handling, and consumption of all food including food and fluids brought to residents by family and other visitors. Procedure, c. Monitor, Community staff will be appointed to check resident refrigerator for proper	F 812	member was unable to place her lunch into the employee breakroom refrigerator due to the surveyors utilizing the room, so she placed it inside this refrigerator located outside the unit's food pantry. It is not a refrigerator the staff use for their personal items, but did so due to the above-mentioned situation. 1. Upon learning of the deficient practice, the food was immediately removed from the refrigerator. No residents were identified as having been affected. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected, however, due to the pandemic, this resident refrigerator has not been utilized. 3. What measures will be put into place (or changes) to ensure that the deficient practice will not recur. All staff will be re-educated at a nutritional education session on February 22 regarding labeling and proper storage. Housekeeping team will be re-educated on daily monitoring to include removal of undated or outdated food. 4. How will the facility monitor its corrective action to ensure it doesn't recur: Housekeeping team will continue its daily check and monitoring. The dietary supervisor will conduct random checks to ensure compliance and include reports in	

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F 812	Continued From page 9 temperatures, food containment and quality, and disposal of items per community policy. Community staff will be appointed to check resident rooms through daily housekeeping process for food and beverage items for safe and sanitary storage and handling. Foods requiring refrigeration will be received by the community designee (activity department, food and nutrition department, charge nurse, etc.) for proper and immediate storage including labeling and dating. Staff will examine food for quality (smell, packaging, appearance) to identify potential concerns. If concerns are identified, staff will notify the resident or resident representative of findings and necessary actions per proper food and beverage safe handling.	F 812	QAA Committee meeting for further review and recommendations.	
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. §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	F 880		3/12/22

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F 880	Continued From page 10	F 880		

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 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

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F 880	Continued From page 11 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 observations, interviews, and record reviews, the facility failed to follow appropriate infection control procedures when 1) licensed practical nurse (LPN)5 brought in a multi-use container of glucometer strips, used to check R175's blood sugar, into R175's isolation room; 2)the facility practice of sharing face shields instead of dedicating face shields to one Health Care Professional was not in compliance. These deficient practices place all residents at risk for the potential spread of infection and/or spread of communicable diseases. Findings include: 1) On 01/27/22 at 11:17 AM, a concurrent observation and interview were done with LPN5 who was going to do R175's scheduled blood glucose check. LPN5 prepared her supplies at her medication cart in the hallway. She stated that the glucometer and associated supplies were used facility wide to check any residents needing blood sugar checks and that there were no separate supplies for residents in isolation. She placed the glucometer (machine to check blood glucose), a bottle of glucometer strips, a piece of two by two gauze, an alcohol prep pad, a lancet (used to prick the finger to obtain blood) and a plastic medication cup on top of a small plastic tray. She carried the tray to the outside of R175's room where there were signs indicating that it	F 880	Multi-Use Glucose Strips: 1. Upon learning of the deficient practice, what corrective action was done: The licensed nurse in question received and completed reeducation on the glucose monitoring including handling and storing of glucose strips. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: During the time of survey there were 3 residents affected (3 residents on accucheck, 2 in green zone and 1 in the yellow zone.) There are 2 glucose monitoring kits and each kit has a designated glucose strips bottle. 3. What measures will be put in place (or changes) to ensure that the deficient practice will not recur: Isolation rooms will have a designated glucose monitoring kit (glucometer, glucose strips bottle, lancets, alcohol swabs, band aid, PDI cloth and glucose control). The kit will be mainly used for isolation room. A glucose strip bottle will not be brought into the isolation room; instead a strip will be taken out from the bottle to be placed in a med cup and covered. That strip in the med cup together with the glucometer, alcohol	

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	125047	A. BUILDING _____ B. WING _____	01/28/2022

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F 880	Continued From page 12 was an isolation room. There was a plastic bin with drawers containing yellow gowns (LPN5 placed her tray on here), a sign indicating that personal protective equipment (PPE; gloves, gown, faceshield) needed to be put on before entering the room, plastic faceshield hanging on hooks on the wall to the left of the doorway, to the right of the doorway there were two black covered bins one to collect trash and another to dispose of the re-usable gowns and a tray holding two containers of disinfecting wipes. LPN5 donned her PPE and proceeded into the room. R175 was sitting up in a wheelchair with the bedside table high across her lap. She placed the plastic tray of supplies unto R175's bedside table. LPN5 proceeded to check R175's blood sugar. She wiped R175's finger with the alcohol prep pad, pricked her finger with the lancet and wearing the same gloves, opened the bottle of glucometer strips, took one strip out, replaced the cap unto the container of glucometer strips, and placed the strip unto the glucometer. LPN5 had to squeeze R175's finger to obtain a blood sample. After R175's blood sugar check, LPN5 placed the tray holding the glucometer and bottle of glucometer strips unto the tray holding the two containers of disinfecting wipes, outside of the room. She removed her PPE and disinfected the supplies. At 12:00 PM, an interview with LPN5 was conducted in the hallway at her medication cart. She stated that she was supposed to have removed a glucometer strip from the container and placed it into the medication cup, instead of bringing in the container of glucometer strips into R175's room, to avoid cross contamination of the bottle of glucometer strips. On 01/28/22 at 11:33 AM, the Director of Nurses	F 880	swab, band aide and gauze, PDI will be placed on tray to use in the isolation room. All reusable equipment will be decontaminated after use. All Licensed staff will complete glucose monitoring/handling and storing strips training. All Licensed nurses will complete CMS videos assigned. All training documents will be completed and submitted. 4. How will the facility monitor its corrective action to ensure it doesn't recur: Licensed staff will undergo monthly competency testing on glucose monitoring/ handling and storing glucose strips will be conducted for 3 consecutive months. Competency will be completed by April. Infection Preventionist will include reports in QAA Committee for further review and recommendations. Use of Face Shields: 1. Upon learning of the deficient practice, what corrective action was done: all staff attending the isolation rooms were identified and a designated face shield was given. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All staff will have a designated face shield labeled with their name that they can use when going into an isolation room. Face shields will be decontaminated after each use and will be stored and hung in a designated area.	

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F 880	Continued From page 13 (DON) and Infection Preventionist nurse (IPN) were interviewed in the DON's office. The IPN stated that multi-use containers, like lotion, would not be brought into a resident's isolation room and therefore the container of glucometer strips should not have been brought into R175's room by LPN5. 2) Observation and concurrent interview were made on 01/25/22 at 09:00 AM outside of Room 220 where face shields were hung outside of door on the wall. Query was made with the Director of Nursing (DON) who stated that shields are used by all staff to go into the room. The shield must be cleaned and hung up outside room. It was not known how long the face shields would stay up on the wall before being replaced. Observation of physical therapist in room with face shield and no goggles on. Interview with Infection Preventionist nurse (IPN) was done on 01/25/22 at 0930 and IPN showed this surveyor the facilities process of cleaning the face shields outside of the rooms. This surveyor shared with IPN that there was a concern regarding sharing face shields. On 01/25/22 at 10:43 AM, research of the Centers for Disease Control and Prevention (CDC) website was done regarding personal protective equipment (PPE) and eye protection was done. (2019). CDC, 2019 states that "In areas of substantial to high transmission in which Health Care Provider (HCP) are using eye protection for all patient encounters, extended use of eye protection may be considered as a conventional strategy. Pertaining to practice in the facility, CDC, 2019 goes on to say that "Eye protection should be removed, cleaned, and	F 880	3. What measures will be put in place (or changes) to ensure that the deficient practice will not recur: Face shields will be changed every week provided integrity remains intact and visibility is not compromised. All staff will complete training on face shield use, decontamination and storage after each use and submit attendance. 4. How will the facility monitor its corrective action to ensure it doesn't recur: - Random floor observation will be conducted by infection preventionist. The infection preventionist will track and audit compliance and submit reports to the QAA Committee for further review and recommendations. The DPOC will be completed and submitted, along with copies of the completed/signed training courses on or before the due date of March 12, 2022.	

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F 880	Continued From page 14 disinfected, it should be dedicated to one HCP and cleaned and disinfected whenever it is visibly soiled or removed (E.g., when leaving isolation area) prior to putting it back on. Record Review (RR) on 01/28/22 shows the Positivity Rate Reporting period from December 27 through January 2, 2022 with the positivity rate at 17.27% and community transmission reported at high. Interview on 01/28/22 at 11:33 AM with the DON and IPN in the DON's office, the DON stated that the facility's use of PPE was not being used in the contingency nor crisis capacity.	F 880		

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E 000	Initial Comments The facility was in compliance with the Health Section of §483.73, Requirements for Long Term Care Facility, Appendix Z, Emergency Preparedness.	E 000		

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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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	125047	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/26/2022**

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K 761 SS=D	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, 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 1/26/22 at approximately 12:15 pm revealed that the facility failed to provide documentation for the annual fire door inspection. The staff member conducting inspections on the fire doors did not receive training on NFPA 80 Fire Door and other	K 761	Upon learning of the deficient practice, a review of the One Kalakaua associate personnel records confirmed that his training received was not verified under NFPA 80 Fire Doors. This One Kalakaua associate was reeducated and completed the NFPA 80 certification training course on February 25, 2022. All residents have the potential to be affected by the practice. One Kalakaua Associate and building management has been re-educated on the requirements under this K761. What measures will be put into place to ensure that the deficient practice will not recur. One Kalakaua will ensure annual re-education is completed by their team, and Human Resources will provide the	2/25/22

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K 761	Continued From page 1 Protective Openings Standard subject matter. These findings were verified at the exit conference with the facility manager and Administrator on 1/26/22 at 1:00 pm.	K 761	facility with proof of re-education. How will the facility monitor its corrective action to ensure it doesn□t recur. One Kalakaua building management will audit and track their records to ensure compliance is maintained. The results of the audit will be reported to the QAA Committee for review and further recommendations.	

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E 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.	E 037		3/31/22

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E 037	Continued From page 1 (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under	E 037		

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E 037	Continued From page 2	E 037		

arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.

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E 037	Continued From page 3 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency	E 037		

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E 037	Continued From page 4 preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: E-037 Emergency Prep This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to produce a complete Emergency Preparedness Plan (EPP) document in accordance with Appendix Z of the State Operations Manual (SOM) and 42 CFR 483.73 for long term care facilities. Training records of annual training of the EPP with staff members was not documented. This deficiency could affect all residents, staff, and visitors during an emergency due to the lack of the required training which would provide knowledge of the facility's EPP. Findings include: An observation on 1/26/22 at approximately 12:30 pm revealed that the facility's Emergency Preparedness Plan's Testing and Training section of the EPP did not conduct annual staff training to reinforce their knowledge of the respective roles and responsibilities when responding to emergencies in the facility, in accordance with Appendix Z of the SOM and 42 CFR 483.73. These findings were verified at the exit conference with the Administrator on 1/26/22 at 1:00 pm.	E 037	Upon learning of the deficient practice, a review of the current new hire and annual EP Training was reviewed. All residents have the potential to be affected by the practice if all staff have not completed their new hire/annual required training of the facility□s Emergency Action Plan. All staff records have been reviewed and confirmed not all staff received their annual training. What measures will be put into place to ensure that the deficient practice will not recur. All current staff will be re-educated on their knowledge of the respective roles and responsibilities when responding to emergencies in the facility. Topics will include, but not limited to: " Purpose of the Plan " What is your role/responsibilities? " Types of Emergencies " Where is the Incident Command Center This re-education will be completed by March 31, 2022.	

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E 037	Continued From page 5	E 037	How will the facility monitor its corrective action to ensure it doesn□t recur. Human Resources department will audit and track all associate personnel files to ensure compliance is maintained, including ensuring all new hires undergo this training as part of their orientation protocols. The results of the audit will be reported to the QAA Committee for review and further recommendations.	