STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING _____ B. WING _____	05/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on May 07, 2021. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. The facility reported incidents investigated were ACTS #8590 and one complaint #8143. ACTS complaint #8590 was substantiated. ACTS #8143 was not substantiated. The highest scope and severity (S/S) = G for F689 Free of Accident Hazards/ Supervision/ Devices. Survey dates: February 22, 2021 to 26, 2021. Survey Census: 79. Sample size: 19.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		6/21/21

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

Electronically Signed | 06/07/2021

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F 561	Continued From page 1 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accommodate one resident's choices to have family visits in the facility, and for an appropriate length of time. The Resident (R)5 was in hospice care which necessitated having visits with family members in the facility. The facility required the resident's family members to have a COVID 19 negative test in order to visit the resident. The family visits were limited to 15 minutes. In addition, the resident did not have a radio at the bedside to listen to music that was noted to be of interest to the resident and included in the care plan. The deficient practice left the resident without social interaction and comfort which had the potential to increase feelings of isolation and loneliness. The required COVID-19 test for visitors, limited schedule of days and time during visit discouraged family members to visit residents in the facility. Findings include: Surveyor observed R5 on 05/05/21 at 10:59 AM laying in bed with the curtain pulled. The room was dark. Noted there was no TV or radio next to the bedside or any bedside table. The resident	F 561	F561 1. Director of Nursing and Administrator reviewed R5 compassion visits with family member. It was noted that all requested in person visits as well as email communication between Director of Nursing and family had in fact been acknowledged and completed as requested. Beginning April 1, 2021 the COVID-19 PCR test requirement had been stopped for all visitors, vendors, and contractors entering the building. A monthly letter is sent to all primary responsible parties and posted on the facility website outlining all visitation requirements. All personnel, including visitors, vendors, contractors, and staff are required to undergo temperature screening and COVID questionnaire completion for entry into the building. Activity staff ensure that R5 has daily access to music and other activities per resident preference. 2. Visitors for all residents will be given access to visits based on Resident	

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F 561	Continued From page 2 appeared awake with her eyes open staring at the ceiling, she said her back hurts. When asked if she wanted to watch tv she shook her head no, and stated, "but I like music." Surveyor interviewed a family member (FM) via telephone call on 05/05/21 at 11:10 AM. When asked if FM felt that R5's choices were being honored and her needs were being met, she responded that she was very frustrated about not being able to see her mom who is in Hospice as often as she would like to. FM stated that the Director of Nursing (DON) said I have to take a COVID test and then its only good for 30 days. "I've been vaccinated and my mothers also been vaccinated, why do I need to get a COVID test anyway?" Then once I got the negative test result I can't visit my mom for more than 15 minutes. She also said we can only visit Monday, Wednesday and Friday which makes it very hard with our schedules. When I do call the DON to schedule, I get her voicemail and leave her a message, I don't get a call back. Its very hard to coordinate. I was waiting for confirmation to visit my mom and the DON only called me back half hour before, its so limited the day and time, its frustrating. Its barely enough time to say hello and goodbye. When the DON told he me needed to get the COVID test, she didn't tell me that it was only good for 30 days and then I needed to get another test. Surveyor interviewed the Administrator on 05/06/21 at 09:34 AM stated that the Administrator sets up the tent visits outside. They are scheduled Monday through Friday for 15, 20 or more minutes. The visits inside the facility are being scheduled by the DON. They are suppose	F 561	preference and ability to participate. Hospice residents and those on quarantine will be given compassion/end of life access visits. All visitors, whether indoor or outdoor tent visits will continue to have temperature and COVID-19 questionnaire screening, wear masks provided by the facility and comply with all infection control requirements during their visits. Facility acknowledges that each resident□s situation is different and must be addressed individually. Tent visits are allowed for thirty to forty five minutes due to infection control cleaning and preparation for the next scheduled visit. 3. All screening staff will be educated to the current facility visitation guidelines to ensure communication consistency with written communication to resident families, 6/7/2021 and ongoing. Written instructions at the screening stations for both the main building lobby and tent visitation area have been updated. Director of Nursing and Administrator will continue to schedule visits with families and provide consistent information both verbally and in writing to avoid any confusion as new updates and guidelines are received from CMS, CDC, and DOH. 4. Director of Nursing and Administrator will monitor visitations for any reported problems experienced by families, friends or residents with the visits. Director of Nursing and Administrator will give report to Quarterly Quality Committee on visitation data and family feedback.	

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F 561	Continued From page 3	F 561		

to call the DON, and they can schedule to see those in Hospice or the residents who cant go downstairs. Family members are not required to get a COVID-19 test. We did require that a long time ago when Center's for Medicare and Medicaid services (CMS) came out with the guidelines and we first allowed visitors into the facility. When surveyor asked if the families are clear on the rules and requirements about the visitation rules the Administrator stated that the information is posted on the website and the facility also sent a letter to the family.

Surveyor reviewed the "inside visitation" screening forms on 05/06/21 at 09:56 AM. Noted each form indicated a COVID test date and result on the top of each page.

Surveyor reviewed the electronic medical record (EMR) for R5 on 05/06/21 at 10:30 AM. R5 has a history of depression, and is currently on medication for depression. R5 also has a history of refusing to eat and is at risk for further decline.

Care plan reviewed.
Problem/ Need: R5 has a history of anxiety, depression, agitation, and restlessness.
Strength: R5 has a daughter who visits her every morning and is available for phone calls.
Interventions.
Encourage socializing with relatives through visits and phone calls...
o Use relaxation techniques such as soft music, deep breathing, visualization.

Surveyor reviewed the Visitors During COVID-19 Pandemic Restrictions effective: 12/16/20, Revised: 03/22/21.
Policy: ...The Director of Nursing will determine

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F 561	Continued From page 4	F 561		

which residents are able to participate in outdoor visits. The DON will be the point of contact for compassionate indoor visits for residents unable to tolerate an outdoor tent visit...

Surveyor interviewed the DON on 05/07/21 at 10:06 AM. At the beginning we required the visitors get a COVID test, I don't remember a date. For those who can't tolerate to go down. The Administrator and I divided the responsibilities. I review and assess the resident and how they can tolerate. Some residents are in quarantine. unless they are dying, I'll make exceptions. With a later instruction from CMS, and Department of health, we are no longer required to ask visitors to test. Most family calls to visit, if they call and leave a message I get back to them or the call is forwarded to the floor. When they call I tell them we don't require testing. We give them 15 minutes at a time for the visit. We allow them to have 15 minutes to minimize the exposure. If the resident is vaccinated we allow them to come and stay longer.

Surveyor interviewed FM a second time on 05/07/21 at 10:26 AM. Stating that her daughter emailed the DON earlier in the week to arrange a visit with R5 today. When she came to visit R5, she was told she was not on the list and had to wait outside. Then they wanted to bring R5 outside, and my daughter told them she can't go outside since she's so frail. Eventually they let her go in to see R5.

Surveyor interviewed the DON on 05/07/21 at 12:19 PM when asked if the radio's are provided by the facility, stated we have radios to give to each resident. The family can also bring a television or radio. Activity aids also have a radio

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F 561	Continued From page 5	F 561		

they go room to room.

Surveyor reviewed the Visitors During COVID-19 Pandemic Restrictions effective: 12/16/20, Revised: 03/22/21.
Policy: ...The Director of Nursing will determine which residents are able to participate in outdoor visits. The DON will be the point of contact for compassionate indoor visits for residents unable to tolerate an outdoor tent visit.

Surveyor reviewed CMS Ref: QSO-20-39-NH September 17, 2020 Revised 03/10/2021. Nursing Home Visitation-COVID-19 (REVISED).
"Indoor Visitation. Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times)...For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.
Visitor Testing and Vaccination...while visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation...
Compassionate Care Visits...Compassionate care visits, and visits required under federal disability rights law, should be allowed at all time, regardless of a resident's vaccination status, the county's COVID-19 positivity rate, or an outbreak." (Cross reference to F563 right to receive visitors).

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F 563	Continued From page 6	F 563		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide three residents (R)5, 47, and 59 the right to have visitors in the facility for a period of time that was acceptable to the Residents and their families. The facility	F 563	F563 Right to Receive/Deny Visitors 1. Administrator and DON discussed visitation concerns with R47. R47 was reassured that all visits with family	6/21/21

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F 563	Continued From page 7	F 563		

required family members to complete a COVID-19 test with a negative test result within 30 days of each visit to the facility. The deficient practice has the potential to increase feelings of loneliness and isolation for residents who reside in the facility. The testing requirement discourages family members to visit family members.

Findings include:

1) Surveyor interviewed R47 on 05/04/21 at 12:47 PM. When asked if he was able to make choices about his care while residing in the facility stated that he would like to have more time to visit with his family. "Even a half hour would be okay, we only get 15 minutes, its just not enough time. The ladies in the front have a timer who tells you times up and my family have to leave. R47 stated that he did not receive any thing in writing about the visit rules. Its only 15 minutes". R47 is a 56 year old alert and oriented male. He has a history of stroke and now stays at the facility.

Surveyor observed the tent in the parking garage on 05/05/21 at 10:30 AM, when asked how long the visits last between the family members and residents, one of the staff stated "15 minutes".

2) Surveyor interviewed a family member (FM) of R5 via telephone call on 05/05/21 at 11:10 AM. who stated that she was very frustrated about not being able to see her mom who is in hospice care as often as she would like to and for more than 15 minutes. FM stated that the Director of Nursing (DON) said I have to take a COVID test and then its only good for 30 days. Once I got the negative test result I can't visit my mom for more than 15 minutes (cross reference F561 choices) it

members were not limited to 15 minutes. R47 has infrequent visits with several extended family members who have all been notified verbally and in writing about the updated facility indoor and outdoor visitation policies. R59 and R32 reside in Facility ventilator dependent unit. Family of R59 has had little to no visits with R59 since R59 admission in 2018. Family is notified in writing monthly of facility visitation however family has not contacted anyone at the facility to request a visit. R32 has numerous family members who arrange visits within the Ventilator unit. They have been updated verbally and in writing monthly about visitation and have not been asked to obtain a COVID-19 test since March 2021.

2. Visitors for all residents will be given access to visits based on Resident preference and ability to participate. Hospice residents and those on quarantine will be given compassion/end of life access visits. All visitors, whether indoor or outdoor tent visits will continue to have temperature and COVID-19 questionnaire screening, wear masks provided by the facility and comply with all infection control requirements during their visits. Facility acknowledges that each resident□s situation is different and must be addressed individually. Tent visits are allowed for thirty to forty five minutes due to infection control cleaning and preparation for the next scheduled visit.

3. All screening staff will be educated to

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F 563	Continued From page 8 seems like its hardly worth all of the effort. Surveyor interviewed the Administrator on 05/06/21 at 09:34 AM stated that the Administrator sets up the tent visits outside. They are scheduled Monday through Friday for 15, 20 or more minutes. The visits inside the facility are being scheduled by the DON. They are suppose to call the DON, and they can schedule to see those in Hospice or the residents who can't go downstairs. Family members are not required to get a COVID-19 test. We did require that a long time ago when the Centers for Medicare and Medicaid services (CMS) came out with the guidelines and we first allowed visitors into the facility. When asked if the families are clear on the rules and requirements about the visitation rules, the Administrator stated that the information is posted on the website and the facility also sent a letter to the family. Surveyor reviewed the visitation schedule on 05/05/21 09:56 AM. Starting in December visits were scheduled Monday, Wednesday and Friday, each in a 1 hour slot. Current week (during the survey) was one visit scheduled on Monday, Tuesday, a few on Wednesday, several on Thursday and Friday. scheduled at 1 hour increments. Surveyor interviewed the DON on 05/07/21 at 10:06 AM. At the beginning we required the visitors to get a COVID test, I don't remember a date. With a later instruction from CMS, and Department of health, we are no longer required to ask visitors to test. Surveyor asked DON if there is a time limit for the family, we give them 15 minutes at a time. We allow them to have a leeway for 15 minutes due to the risk of exposure,	F 563	the current facility visitation guidelines to ensure communication consistency with written communication to resident families, 6/7/2021 and ongoing. Written instructions at the screening stations for both the main building lobby and tent visitation area have been updated. Director of Nursing and Administrator will continue to schedule visits with families and provide consistent information both verbally and in writing to avoid any confusion as new updates and guidelines are received from CMS, CDC, and DOH. 4. Director of Nursing and Administrator will monitor visitations for any reported problems experienced by families, friends or residents with the visits. Director of Nursing and Administrator will give report to Quarterly Quality Committee on visitation data and family feedback.	

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F 563	Continued From page 9	F 563		

if the resident is vaccinated we allow them to come and stay longer.

During an interview with a Registered Nurse (RN) on 05/06/21 at 10:50 AM, stated they schedule the visits everyday and we get a list of the names and times of the residents on our unit. The visits last 15 minutes.

Surveyor reviewed the Visitors During COVID-19 Pandemic Restrictions effective: 12/16/20, Revised: 03/22/21.
Policy: ...2 visitors per resident, with a visit limit of 15 minutes...

Surveyor reviewed CMS Ref: QSO-20-39-NH September 17, 2020 Revised 03/10/2021. Nursing Home Visitation-COVID-19 (REVISED). "Visitor Testing and Vaccination...while visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation...
3) Interview on 05/06/21 at 2:45 PM with Director of Nursing (DON) was done. DON stated that she handled the visitations in the facility and the administrator handled the visits outside in the tent. DON stated there was no COVID in the facility and that 20 residents have not received vaccination.

Resident (R59)'s family (F)1 was interviewed on 05/07/21 at 11:46 AM. F1 stated that he had not seen R59 since COVID started. F1 stated that he was notified of the visits with one of his bills. R1 said he still must get a COVID test and the time to visit is limited to 15 minutes. It's not that easy. F1 went on to say that he has not been notified about not needing a COVID test. He also does

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F 563	Continued From page 10 not go on the web. R32's family (F)2 was interviewed on 05/07/21 at 11:31 AM. F2 stated she had a COVID test scheduled next week to visit. F2 stated, I must get a COVID once a month to visit and its only for 15 minutes once a week. The cost of the test and minimal amount of time to visit was hard. F2 further stated that she was not aware she did not need a COVID test to visit and was not notified about this change. Interview with DON on 05/07/21 at 09:20 AM. DON stated they had the current guidelines distributed by Centers for Medicare and Medicaid Services	F 563		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. 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	F 623		6/21/21

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(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.

§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;

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F 623	Continued From page 12 (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 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 review and interviews, the facility failed to send a copy of the transfer notice to a representative of the Office of the State	F 623	F623 483.15(c)(3)-(6)(8) 1. Facility Social Worker immediately	

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F 623	Continued From page 13 Long-Term Care Ombudsman. Findings: Record Review (RR) of resident (R)59 on 05/05/21 at 09:31 AM was done. RR revealed R59 had gone to the emergency room a few times for pneumonia and bloody stools, R59 was hospitalized 3/19/21 at an acute care hospital. Surveyor was not able to find a notice to the Ombudsman. Interview on 05/07/21 at 11:27 with Social Worker (SW) was done. SW stated that it would be done by the nurses on weekends and that they have a binder on the floor. Interview on 05/07/21 at 12:00 PM was done with Unit Supervisor (Supvr) 2. Supvr 2 went through the binder with surveyor. The binder did not hold any document of notice to the State Long-Term Care Ombudsman. Supvr 2 agreed that it was missed and was not aware of the binder and/or process. Supvr 2 stated "it could have been missed on the weekend."	F 623	submitted a late Transfer/Discharge Notice to the Ombudsman□s Office of (R)59s 03/19/2021 hospitalization. Notice and faxed confirmation copy placed in Social Work Office Log Book. 2. Four in-services were held with licensed nursing staff on 5/18/2021 and 05/25/2021 to review the facility policy and procedure, dated 11/08/2018, pertaining to the Transfer/Discharge Notice. Education included the requirements of notifying the Ombudsman□s Office when a resident is transferred from the facility for hospitalization or therapeutic leave and the responsibility of licensed staff to complete the notification process during non-social work on-site work hours. The assigned social worker faxes the Notice to the Ombudsman on all scheduled transfers (lateral) or discharges. Copies are kept in the social work office. Nursing will complete the Transfer/Discharge Notice to the Ombudsman for all transfers for 911 or AMR calls. The Nursing department will fax the completed form to the Ombudsman. The form and the fax confirmation will be filed in a binder, kept at the nursing station. Each nursing station has its□ own binder for the residents on each respective unit. Social Worker will be notified of transfers by nursing, during weekday morning Interdisciplinary Team Meetings (IDT). The social worker will log all transfers made by nursing on the facility Transfer/Discharge Tracking Form. Social worker will also check the binder to	

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F 623	Continued From page 14	F 623	make sure that the Transfer/Discharge Tracking Form and fax confirmation sheet have been filed. 3. Four in-services were held on 5/18/2021 and 05/25/2021, to educate staff that this practice of notifying the Ombudsman was established on 11/08/2018 and is required. Nursing Supervisors will include orientation on the Ombudsman Transfer/Discharge Notice during new hire nursing orientation on the units. Nursing supervisors will remind licensed nursing staff as needed at monthly nursing staff meetings. Social workers will track unplanned, non-scheduled transfers/discharges from the nursing units. Scheduled and planned discharge Notices to the Ombudsman will continue to be completed and logged by the social workers. 4. Social workers will be notified during weekday IDT meetings of unplanned transfer/discharges from the nursing units. Social workers will log the transfers on the Transfer/Discharge Tracking Form. Social workers will send out the Notice to the Ombudsman for any missed transfers/discharges as soon as they are notified. Social work will monitor logs and report compliance to the Qtrly QA Committee Monitoring results will be reported at the Quarterly Quality Meeting.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		6/21/21

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F 677	Continued From page 15 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to identify poor oral health for one Resident (R)65 had foul mouth odor. The deficient practice placed the resident at a high risk for illness. Findings include: R65 is a 78 year old man who has a diagnosis of dysphagia (difficulty swallowing) requiring Gastrostomy tube (G-tube) feeding (parenteral nutrition). The resident is totally dependant on staff for his routine care and activities of daily living. During an observation on 05/04/21 at 02:35 PM. Surveyor attempted to engage R65 in conversation. Resident appeared to be non English speaking but opened his mouth to say some words. Surveyor noted a strong foul mouth odor. The resident in the bed next to the door stated that the resident (R65) is only Chinese speaking. His teeth appeared intact. During another observation on 05/06/21 at 02:50 PM, surveyor did not see a toothbrush or toothette on the bedside cabinet. Resident was sitting upright in bed awake and alert. Surveyor reviewed the Policy and procedures "Oral Assessment dated 08/24/11; and procedure for Oral Hygiene dated 11/95; 5. Care for the unconscious or edentulous resident with no dentures. b. Clean mouth using toothette's	F 677	F tag □ 677 ADL Care Provided for Dependent Resident 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident - R65 oral hygiene/care included with her ADL care was done immediately on 5/7/2021 and on going. Director of Nursing will review and re implement the Policy and Procedure on Oral care/hygiene included with ADL care to all nursing staff on 6/7/2021 and on going. Staff will be reeducated that Oral assessment by the Dentist is done annually and residents will be referred on a prn basis if an oral problem occurs. Nursing staff will be educated to perform and demonstrate oral hygiene correctly with sign in sheet on 6/7/2021 and on going. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Upon admission, resident initial oral care assessments are completed. This follows on quarterly, annually and prn. Oral Care assessments are included in residents electronic record system. Referral will be	

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F 677	Continued From page 16 moistened with water and mouthwash. Rub toothette on chewing, inner, and out surfaces of teeth. Swab roof of mouth, inside of cheeks and along gum lines, and lips. Swab tongue. Apply petroleum jelly to lips." Surveyor observed R65 in bed on 05/07/21 at 10:55 AM , with certified nurse aide (CNA) 15 at bedside with shower gurney. CNA15 stated R65 just came back from shower. When asked how often his oral care is done and how does she clean his mouth stated, we use the toothette's. Interview with Registered Nurse (RN)25 on 05/07/21 at 11:07 AM at the nurses station. Surveyor asked if RN25 is aware of the strong mouth odor that R65 has? RN1 stated yes that he was aware, and that he ask's the CNA's to provide oral care for R65 a couple of times a shift so I don't know why its like that. Sometimes R65 refuses when they tray and he shakes his head no. He is Chinese speaking so we try to communicate with him by using gestures. When asked how often he gets an oral exam stated, I'm not sure, I think a reminder will come up in the computer, to remind us when its due. Surveyor reviewed residents hard chart on 05/07/21 at 11:28 AM. Initial/ Annual oral assessment dated 04/10/20. Missing teeth, #18 #19 #28. Root exposure and blackened areas. Gingiva is pink. Surveyor reviewed the Dental Consult for R65 dated 11/09/20. "patient presents for consult regarding fractured teeth, whether he can proceed to eat. Oral hygiene is fair... Surveyor interviewed the Director of Nursing (DON) on 05/07/21 at 12:34 PM and discussed	F 677	made to the Dentist whenever there is a problem encountered in oral cavity such as pain, toothache or foul odor. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Director of Nursing will develop a Monitoring Log sheet for residents oral care/hygiene compliance every shift. RN Supervisor will monitor oral assessment completion and submit to the Director of Nursing every week for 3 months, then yearly thereafter. Provide adequate oral hygiene supplies for Certified Nurses Assistance/ Licensed Nurses to use and monitor supply availability daily x 1 month, weekly x 3 months then monthly x1 year. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur again. What program will be into place to monitor the continued effectiveness of the systemic changes. Director of Nursing or designee will monitor Oral Hygiene Tracking Log completion and compliance and present to Quarterly Quality Committee.	

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F 677	Continued From page 17 R65's oral status. The DON stated that the nurses don't need to wait for the annual dental oral assessment, if there is a concern they can refer R65 for a dental consult.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide Resident (R)234 more interventions to ensure a safe environment to prevent her from falling. This deficient practice caused R234 to sustain a right hip fracture and needing care in an acute facility. This can potentially affect residents who are at a high risk for falls placed into quarantine. Findings include: A record review was done on 05/05/21 at 2:25 PM of R234's completed facility reported incident (FRI). R234 sustained a fall on 11/30/20 at 1:35 PM and was admitted to a local hospital on 12/02/20 for a right hip fracture. R234 was an 87-year-old female admitted to the facility on 11/17/20 for rehabilitation services. Her diagnoses included stroke with right sided weakness, dementia (the loss of cognitive functioning to such an extent that it interferes with	F 689	F tag □ 689 Free of Accident Hazards/Supervision Devices **IDR For F-tag 689 Submitted 06/04/2021, pending. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident □ 234 who had a fall and injury last 11/30/2020 and was discharged from Pearl City Nursing Home and no longer in the facility. Corrective Actions implemented for the future: 1. Reviewed Policy and Procedure of Fall Prevention with all staff, with sign in sheets on 6/7/2021 and on going. DON will continue to review with nursing staff	6/21/21

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F 689	Continued From page 18 a person's daily life and activities) and she sustained a fall at home prior to her admission to the facility. At the facility, R234 was in contact isolation and under quarantine for 14 days to rule out COVID-19. The FRI further stated " ...She is unable to express needs and wants with poor safety awareness ..." Review of R234's EMR revealed that her medical diagnosis for her admission into the facility was "aphasia following unspecified cerebrovascular disease" (difficulty communicating after a stroke). A physician encounter note for 11/17/20 described R234 as "...Unsteady, muscle weakness, high risk for falls Poor memory and safety awareness..." Health status progress notes in R234's EMR revealed that she was alert and oriented to self only and needed one-to-two-person assistance with her activities of daily living (ADL; tasks performed routinely i.e., eating, dressing, eating), moving from bed to wheelchair and vice versa and walking. Health status progress note of 11/20/20 stated, "...resident is confused and tends to get out of bed & always moving around on her bed..." A Social Services note documented on 11/20/20 stated that with the help of an Ilocano interpreter "...she usually gets up at least 5 times throughout the night, to use the restroom when she was at home. When at home resident was ambulatory with a walker, and independent with her ADLs..." A Health Status note documented on 11/21/20 revealed that R234 was "...forgetful & confused at times. Keep moving in bed, tossing & turning, high risk for fall..." An Incident Note on 11/23/20 documented that R234 fell from her wheelchair when she was left unattended in her room after therapy, despite having an accessible call light and a personal alarm.	F 689	prn. 2. Re-enforced the implementation of 4 Ps for Admission Alert for falls which are the following: 1. Pain □- check resident every shift and prn and medicate prn. 2. Potty □- toilet resident every 2 hours and prn. 3. Personal items -□ check personal items to be within reach of resident. 4. Positioning □- reposition every 2 hours and prn. 3. Falling Star □ implemented at room door to visually signify to staff that resident is at risk for fall. 4. Round on newly admitted resident every hour for [24] x5 days until stable and a baseline assessment is completed including cognitive status. Completed staff review on 6/7/2021 and ongoing. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? a) Due to COVID-19 admission protocols, newly admitted residents are placed in isolation rooms. COVID Vaccinated resident for 5 days, Unvaccinated resident for 14 days. b) Upon admission, Licensed staff will complete initial fall assessment to determine if resident is at risk for fall, poor safety awareness, or had a history of fall. From initial assessment, Licensed Nurse will determine the need for a low bed, bed side mat and bed/personal/wheelchair	

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F 689	Continued From page 19 A review of R234's "At Risk for Falls" care plan revealed that interventions dated for her admission of 11/17/20 revealed no plan for increased rounding by staff despite R234 experiencing a fall at home prior to admission. There was also no plan for increased staff monitoring after her first fall in the facility on 11/23/20. An intervention to not leave the resident unattended in her room was also not documented. This was an intervention identified to be included in R234's care plan after her 11/23/20 fall as stated in the "Resident Incident Report" of 11/23/20. In an interview with the DON on 05/06/21 at 3:10 PM, she was queried as to why R234 was not placed closer to the nursing station after her first fall and she stated that there was no vacant room, so they did not relocate the resident. An interview with the speech language pathologist (SLP) on 05/07/21 at 11:17 AM was done. The SLP was asked about the second fall R234 had on 11/30/20. She stated that she saw R234 by the door to the room. R234 told her that she was "getting up to go and wash the dishes." SLP stated, "I must have heard the alarm" and that's why she went towards the room. She further stated that R234 was alone in the room and "was nowhere near the bed." In another interview with the DON on 05/07/21 at 2:24 PM, she stated that R234 was not relocated to a different room because she was under quarantine for COVID-19. She did her rounds on the units and did not receive a report of R234 getting out of bed and that R234 remained calm and stayed in bed. She also stated that she did	F 689	alarm if indicated. c) Nursing staff will observe residents behavioral adjustment and determine if resident needs to be located closer to the nursing station. If observation includes persistent restlessness and/or agitation, facility will implement 1:1 assistance for safety. d) Family member(s)and/or ROP will be notified to visit resident for compassion visits to make resident feel secure and improve orientation. e)Quarterly, significant change and annual fall assessments will be done thereafter and on going. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. a) Upon admission, initial assessment for fall risk will be completed. b) Implement Monitoring Log for Fall to track identified resident at risk for fall. c) Quality Assessment and Prevention Intervention which consist of Interdisciplinary Team will meet after each fall incident to discuss the Root Cause Analysis of the fall. d) IDT will revise care plan and implement interventions to prevent further fall. e) RN Supervisor will monitoring Tracking Log for falls every week x 3 months and monthly for a year. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur again. What program will be	

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F 689	Continued From page 20 not update R234's care plan with the intervention of not leaving the resident unattended in her room. Surveyor asked the DON for documentation indicating that frequent rounding was done by staff, but none was received.	F 689	into place to monitor the continued effectiveness of the systemic changes. a) Director of Nursing and/or designee will review fall outcomes on Monitoring Log and make adjustments according to results. b) Director of Nursing and/or designee will implement new adjustments and continue to review monthly. c) Director of Nursing and/or designee will monitor the tracking tool for fall incidents every month x 6 months, then quarterly. DON will submit report to the Quality Improvement meeting every quarter.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 observations, interviews and record review, the facility failed to appropriately treat Resident (R)233's pain consistent with professional standards of practice as outlined in the Centers for Medicare and Medicaid Services (CMS) State Operations Manual - Appendix PP, Guidance to Surveyors for Long Term Care Facilities. This deficient practice can potentially impair R233's function, mobility and mood thereby diminishing her quality of life and can affect all residents experiencing pain.	F 697	F tag □ 697 Pain Management 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Director of Nursing will review Policy and Procedure for Pain Management with all Licensed Nursing Staff on 6/7/2021. Licensed Nursing Staff will watch the Pain Management Video on 6/8/2021 and on	6/21/21

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F 697	Continued From page 21 Findings include: An initial observation of R233 was done on 05/04/21 at 10:28 AM. R233 was calling out for help. A sign for "Contact Isolation" was posted above the room number. She was grimacing and her eyes were clenched closed while the surveyor asked if she was okay. R233 did not answer the surveyor and continued to ask for help. A record review of R233's electronic medical record (EMR) was done later that same day at 1:18 PM. R233 was admitted on 04/27/21 from a local hospital for hospice services. She had a diagnosis for gangrene (dead tissue) of her right foot. Physician's orders revealed that R233 had Tylenol Tablet (over the counter pain medication) and Oxycodone Hcl (hydrochloride; opioid pain medication) ordered to be given when she complained of pain. Social Services and Health status progress notes showed that she was alert and oriented to self, place, and time. She had gangrene of both her right and left feet and wore foam boots. R233's care plan did not describe any non-medical interventions for management of her pain. An observation and attempt at an interview were made with R233 on 05/05/21 at 10:52 AM. A television was next to her bed, but it was not on. R233 stated that she liked to watch television, but the cable was not working in her room. Surveyor confirmed with R233 that watching television would distract her from her pain. The interview was terminated because she was not conversive and stated, "okay" to all questions asked. A record review on 05/05/21 at 2:40 PM of the facility's "Pain Management" policy effective	F 697	going. Pain assessment every shift will be included as the 5th Vital sign in residents electronic record system. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Upon admission, Nursing Staff will complete initial Pain Assessment on all residents in electronic system and determine if resident is in pain. This will include quarterly, annual and any significant change in condition assessments. Licensed Staff will follow non-pharmacological intervention as well as pharmacological intervention if ineffective. Licensed Staff will also follow the Pain Scale System 0-10 accordingly for pain evaluation. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Director of Nursing will develop Monitoring Log to track the completion and accuracy of Pain assessment in residents electronic system. RN Supervisor will monitor the completion of Pain Management Log every week for 3 months then monthly x 1 year.. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, o.e. What program will be into place to monitor the continued effectiveness of the systemic changes.	

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F 697	Continued From page 22 02/19/07 revealed " ...6. Non-pharmacological intervention should be offered and taught: a. Cold packs as prescribed b. Repositioning, turning and/or ambulating as tolerated. c. Relaxing exercises i.e.: deep breathing, rhythmic breathing and/or "peaceful past" memory meditation. d. Distraction ..." Another observation and an attempt at an interview were made with R233 on 05/06/21 at 08:25 AM. R233 was lying in bed with her breakfast tray in front of her, 40% was eaten. She was grimacing and her eyes were clenched closed. Surveyor asked her if she was experiencing pain and she stated, "yes." R233 stated that she needed her more pain control and rated her pain eight out of ten (on a pain scale with zero being no pain to ten being excruciating pain). Surveyor informed registered nurse (RN)3 that R233 was complaining of eight out of ten pain at 08:36 AM. RN3 stated "Okay" and continued to prepare her medications for her residents. Periodic observations of RN3 revealed that she continued to prepare and administer medications to residents until 09:34 AM when surveyor queried RN3. RN3 was asked if R233 received any pain medication this morning when surveyor informed her of R233's pain and she stated "no." RN3 further stated that she had recently asked R233 if she had pain and resident stated "no." Surveyor observed R233 lying in bed snoring. On 05/06/21 at 09:26 AM, an interview with RN4 was conducted at the unit's nursing station. RN4 was queried as to what the nursing process was	F 697	Director of Nursing and/or designee will monitor Pain assessment log every month. Reports will be submitted to the Quarterly Quality Improvement meeting.	

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	125043	A. BUILDING _____ B. WING _____	05/07/2021

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F 697	Continued From page 23 for when a resident complains of pain and she stated that her process is to immediately assess the resident, try to reposition the resident if needed or provide distraction activities and administer pain medication as appropriate. She stated that if she were in the middle of medication preparation for other residents, she would make sure she labeled the medication cup, put it in a safe place, lock her cart and assess the resident. On 05/07/21 at 10:15 AM, an interview was conducted with the Activities Aide (AA) in the recreation room, and she stated that R233 did not have cable for her television because the "family" needed to set up cable service. The AA stated that she did activities with R233 in the afternoon and noted that resident did have a "lot of pain." On 05/07/21 at 10:30 AM a review of R233's medication administration record (MAR) was done. Oxycodone Hcl 5 mg (milligrams), 0.5 tablet (or 2.5 mg) was given once on 05/02/21. Oxycodone 5 mg, one tablet was given once on 05/03/21. Tylenol tablet 325 mg, two tablets were given once each day on 05/04/21 and 05/05/21. The State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities (Rev. 11-22-17) stated, "Because pain can significantly affect a person's well-being, it is important that the facility recognize and address pain promptly." Strategies for pain management include " ...Developing and implementing both non-pharmacological and pharmacological interventions/approaches to pain management ..."	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l)	F 698		6/21/21

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F 698	Continued From page 24 §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 observation, interview and record review, the facility failed to ensure dialysis services were consistent with professional standards of practice. This deficient practice has the potential to affect other dialysis residents in the facility who require dialysis. Findings include: Interview was done on 05/06/21 at 11:39 AM with Unit Supervisor (Supvr)2. Supvr2 stated that resident (R)79 was admitted to the hospital from after leaving the facility from the dialysis center. Supvr2 stated that the transporter called the facility inquiring where the resident was for pick up. Approximately at 4:30 PM, the facility called the dialysis center to inquire where R79 was. The dialysis center stated that at 2:00 PM, they sent the resident to the emergency room. The dialysis center stated they were about to call the facility to inform them that R79 was sent out to the emergency room because of mental status changes. Supvr 2 stated she followed up with the hospital and R79 was admitted. Supvr2 stated that the dialysis center is supposed to communicate with the facility via the dialysis communication record (DCR), however, no DCR or phone call had been received. Supvr 2 stated that she is still waiting for a DCR from the dialysis center. DCR was not received until 05/06/21 at 2:30 PM. R49 was	F 698	F tag □ 698 Dialysis 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Director of Nursing will develop a Notification Memo to all dialysis facilities instructing them to inform our facility by phone whenever they send our resident to the hospital or Emergency Room. The Memo will be attached to the resident□s communication book (pre- and post dialysis folder). Corporate Contract Officer working with Dialysis Centers to revise and update existing contracts. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Upon admission, Nursing Staff will determine if resident is on dialysis. A dialysis communication folder will be implemented which consists of the scheduled days and times of the dialysis schedule. This form will be filled out by Nursing Staff pre- dialysis and the dialysis staff will complete post- dialysis	

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F 698	Continued From page 25 admitted to an acute facility on 05/05/21 at approximately 2:00 PM according to Registered nurse (RN)2. Treatment was scheduled for 11:45 PM to 3:15 PM on 05/05/21 with the dialysis center. Record review on 05/07/21 at 09:52 AM of the facilities contract revealed a contract dated from 2011 and 2012 with a previous administrator's name. Record review on 05/07/21 at 10:00 AM of facilities policy and procedure dated April 29, 2011 states under Procedure: 4. The facility will communicate with dialysis agent any significant medical/health changes the resident may encounter. The dialysis agent is also expected to provide similar notifications affecting the resident while on dialysis. 5. The facility will manage the resident's care and well being in collaboration with the recommendations and treatment modalities set forth by the dialysis agent. 6. The facility will be responsible in arranging transportation (e.g. family transport other private arrangements) and escort as appropriate, to ensure safe arrival to and departure from the dialysis site. Interview on 05/07/21 at 10:30 with the Director of Nursing (DON) and Administrator. DON stated that the contract was old. The facility did not update the contract because the residents who were admitted to the facility from dialysis are already in place before they even come here. The DON and administrator understood the event of miscommunication for R79 was not professional standards of practice. This deficient	F 698	observation. Notification Memo will be attached to the Communication Folder each time resident will go to dialysis appointment. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Nursing Staff will be educated on the Notification Memo that goes with the dialysis communication folder each time resident goes for dialysis.. Director of Nursing will in-service nursing staff on the implementation of the Notification Memo for all residents going to dialysis and on going. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, o.e. What program will be into place to monitor the continued effectiveness of the systemic changes. RN Supervisor will submit monitoring log every week for 2 months and monthly for a year to the Director of Nursing. Director of Nursing and/or designee will monitor the completion of dialysis communication folder every week for residents on dialysis. Reports will be presented to Quarterly Quality Improvement meeting.	

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F 698	Continued From page 26 practice has the potential to affect other dialysis residents in the facility.	F 698		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and review of equipment service manual, the facility failed to ensure routine maintenance of the air particle filter, based on the manufacturer's recommendation, for one two of four oxygen concentrators reviewed. This deficient practice put Resident (R) 42 and Resident (R) 63 at risk for the development and transmission of communicable diseases and infections. Findings Include: 1. During an observation, on 05/05/21 at 11:00 AM, of R42's room, a NewLife Elite Oxygen Concentrator was noted at bedside providing oxygen to R42. The air particle filter located on the back of that oxygen concentrator appeared dirty with lint and/or dust on it. A review of the Electronic Health Record (EHR) showed that R42 was admitted on 03/20/20 with a diagnosis of Chronic Respiratory Failure, Cardiac Arrest, Congestive Heart Failure, Tracheostomy, Atrial Fibrillation, Dysphagia, Gastrostomy, Hyperlipidemia, Hypertension, Dementia, Quadriplegia. R45 had a doctor's order to use oxygen with the ventilator.	F 908	F-tag 908 483.90(d)(2) 1. All in-use oxygen concentrators and filters in facility were immediately cleaned and checked per the manufacturers standards to ensure safety and infection control for the effected residents. 2. Maintenance Department personnel will complete weekly inspection and cleaning of all in-use oxygen concentrators and filters per manufacturers operating manual guidelines. Cleaning will be logged in the Weekly Concentrator Preventative Maintenance Log form. 3. Maintenance Department personnel will ensure all oxygen concentrators are checked weekly and monthly to ensure they are in good working order. Items noted needing preventative maintenance will taken out of use and exchanged for working units to ensure resident safety and infection control. 4. Maintenance Coordinator will monitor logs and report compliance with	6/21/21

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F 908	Continued From page 27 2. During an observation, on 05/05/21 at 11:15 AM, of R63's room, a NewLife Elite Oxygen Concentrator was noted at bedside providing oxygen to R63. The air particle filter located on the back of that oxygen concentrator appeared dirty with lint and/or dirt on it. A review of the EHR showed that R63 was admitted on 04/02/21 with a diagnosis of Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Heart Failure, Respiratory Failure with Hypoxia, Respiratory Failure with Hypercapnia, Atherosclerotic Heart Disease, Hyperlipidemia, Encephalopathy, Meckel's Diverticulum, Colitis, Acute Kidney Failure, Vascular Disorder of Intestine, Emphysema, Colostomy, Gastrostomy, Tracheostomy, Dysphagia, Septic Shock, Paralytic Strabismus. R63 had a doctor's order to use oxygen as needed. On 05/06/21 at 11:20 AM, Staff Nurse (Nurse) 1 was queried about the air particle filter cleaning process. Nurse 1 stated that they did not clean that filter and that they did not have any current process in place to clean it. On 05/06/21 at 11:30 AM, Unit Supervisor (Supvr) 2 was queried about the air particle filter cleaning process. Supvr 1 stated that they did not clean that filter and did not have any current process in place to clean it. On 05/07/21 at 11:32 AM, a review of the Service manual for the NewLife Elite Oxygen Concentrator, Section 3.2.1 - Cleaning the air intake gross particle filter stated the following: the patient must clean this filter weekly ... The filter may require daily cleaning if the NewLife unit operates in a harsh environment ... Section 4.1.1	F 908	inspection and cleaning to the Quarterly Quality Committee.	

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F 908	Continued From page 28 Air intake gross particle filter stated the following: the external air intake gross particle filter is located on the back of the unit. You can easily remove it by hand. Instruct the patient to clean this filter weekly.	F 908		

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E 000	Initial Comments A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on 05/04/21 to 05/07/21. The facility met the Health Safety Requirements of Appendix "Z", for emergency preparedness and response; in accordance with 42 CFR 483.73 requirement for Long term care facilities	E 000		

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

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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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K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Management Solutions, LLC on behalf of the Department of Health, Office of Health Care Assurance on August 18, 2021. The Facility was found not to be in compliance with the requirements of 42 CFR 483.90. Pearl City Nursing Home is a five-story nursing facility. The fifth floor is administrative and offices, the fourth, third and second are certified nursing floors and the first floor is dietary services. The facility was constructed in early 1997 of concrete steel protected roofing with tile facing, concrete flooring and concrete stucco bearing walls. The facility has a 150 Kilowatt (KW) diesel generator that supplies back up power to the entire building.	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure that one of two exit discharges was maintained in accordance with NFPA 101 (2012 edition) section 7.1.10.1. This had the potential to affect half of the resident population or 41 residents. Findings include:	K 271	The Maintenance Department adjusted the door jam to allow proper opening and closing of the door without excessive force. (08/19/21) All other exit discharges were checked during the Life Safety Code survey by the representative of Healthcare Management	8/19/21

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K 271	Continued From page 1 Observation of the discharge door off the stairway leading to exit at the kitchen on the ground floor on 08/18/21 at 12:45 PM revealed when opened from the inside, the exit access stairway door required vigorous effort on the part of the surveyor. The door was stuck in the frame and had to be opened with significant effort and two attempts. Interview with the Environmental Services Director at the time of the observation verified the exit door was difficult to open. The code under NFPA 101 section 7.1.10.1. requires, "Means of egress shall be continuously maintained free of all obstructions and impediments to full instant use in the case of a fire or other emergency."	K 271	Solutions, LLC. (08/18/21) Added an exit access door check to the weekly preventative maintenance walkthrough. (08/19/21) Any issues will be reported to the Administrator at the daily Administration meeting. (08/19/21) If necessary, ongoing issues will be escalated to the quarterly QAPI meetings and addressed accordingly. (08/19/21)	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of	K 351		9/17/21

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K 351	Continued From page 2 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure it maintained complete sprinkler coverage throughout the building in accordance with NFPA 13 (2010 edition) section 8.1.1. The lack of sprinkler coverage could allow the spread of smoke and fire throughout the building without containment. This had the potential to affect the safety of all 82 residents. Findings include: Observations of the walk-in freezer and walk-in refrigerator on 08/18/21 at 10:00 AM revealed both lacked sprinkler coverage. The freezer measured 6 feet wide by 8 feet deep. The refrigerator measured 8 feet wide by 15 feet deep. Interview with the Environmental Services Director at the time of the observation verified the walk-in refrigerator and walk-in freezer lacked sprinkler coverage. Both contained large electric motors powering the fans to chill the rooms. The code requires under NFPA 13 (2010 edition) section 8.1.1. that sprinkler coverage shall be installed throughout premises.	K 351	K351 The installation of the walk-in freezer and refrigerator sprinkler heads will occur on September 17, 2021, done by an outside contractor, Hawaiian Dredging, LLC. (09/17/21) Complete sprinkler coverage was checked during the Life Safety Code survey by the representative of Healthcare Management Solution, LLC. (08/18/21) Since proper sprinkler coverage was checked, and there are no plans to move any sprinkler heads, or construct any additional areas, this is not considered an ongoing issue. (09/17/21)	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in	K 521		8/24/21

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K 521	Continued From page 3 accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation, fire alarm record review and interview with the facility Environmental Services Director, the facility failed to ensure that three of three smoke dampers located on three separate smoke barrier walls HVAC (heating, ventilation, and air conditioning) system were maintained in accordance with NFPA 101 (2012 edition) 9.2.1 to NFPA 90A (2012 edition) section 5.4.8.2 to NFPA 105 (2010 edition) 6.5.2 to 6.6.5. This had the potential to affect the safety of all 82 residents. Findings include: Observations of smoke dampers from the corridor on three smoke barrier walls located near bedrooms 402 at 9:55 AM, 302 at 10:05 AM, and 202 at 10:20 AM on 08/18/21 revealed the smoke dampers were present on the ventilation duct passing through the smoke barrier walls. Interview with the Environmental Services Director on 08/18/21 at 11:05 AM revealed he called the contractor and was unable to locate a maintenance report for the smoke dampers. There is no smoke damper maintenance report over the past four years. Review of the annual fire alarm inspection report located in the fire safety binder dated 05/27/21	K 521	K521 Systems Engineering Group, LLC was contacted to perform smoke damper maintenance and testing. Project was completed on August 24, 2021. (08/24/21) The company responsible for our fire alarm system inspection was notified that the smoke dampers need to be added to the maintenance and testing every four years. (08/24/21) The Environmental Services Coordinator will add the smoke damper maintenance and testing reports to the fire safety binder. (08/24/21) Any issues found during the inspection will be brought to the Administrator's attention during daily Administration meetings. (08/24/21) If necessary, ongoing issues will be escalated to the quarterly QAPI meetings and addressed accordingly. (08/24/21)	

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K 521	Continued From page 4 revealed no reference to smoke dampers in the report. The code requires under NFPA 101 (2012 edition) section 9.2.1 refers smoke damper maintenance to NFPA 90A (2012 edition) section 5.4.8.2. referring to NFPA 105 (2010 edition) section 6.5.2. requiring smoke damper maintenance every "four years." Section 6.5.7. requires "testing to prove there is no interference," section 6.5.8. testing that "damper frame has no penetrations of foreign objects that would affect operation," section 6.5.9. that "Damper must be verified it is not blocked," section 6.5.10 "reinstall fusible link after testing, section 6.6.2. that "all exposed moving parts shall be dried lubricated," and section 6.6.5. "that all smoke damper actuation shall be initiated according to the manufacturer with all such actions documented."	K 521		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918		9/9/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/18/2021**

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K 918	Continued From page 5 simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to ensure the 150-Kilowatt (KW) diesel generator was maintained in accordance with NFPA 110 (2010 edition) section 17.3.4.3. and NFPA 110 (2010 edition) 7.3.2 by failing to conduct a load bank test in the past three years and failing to provide emergency lighting in the generator room. This had the potential to affect the safety of all 82 residents in the facility. Findings include: 1. Review of the contractor documentation for the generator dated 05/10/21 revealed no reference to a load bank test in the past year. Further review of facility documents revealed no evidence of a load bank test in the past three years.	K 918	K918 (1) An outside contractor, Spectrum Engineering, conducted the 4-hour load bank test according to requirements. (08/25/21) The Environmental Services Coordinator will add the 4-hour load bank test reports to the generator maintenance binder. (08/25/21) The Environmental Services Coordinator will add the 4-hour load bank test requirement to the generator testing logs to be done annually. (08/25/21) Any issues found during the inspection will be brought to the Administrator's attention	

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K 918	Continued From page 6 Interview with the Environmental Services Director at the time of the review confirmed the facility did not have documentation of a load bank test completed in the past three years. The code under NFPA 110 (2010 edition) section 7-13.4.3. requires "A load test shall be applied for 4 hours, full load test. The building load shall be permitted to serve as part or all of the load, supplemented by a load bank of sufficient size to provide a load equal to 100% of the nameplate KW rating of the EPS [Emergency Power System]." 2. Observations of the generator room near the garage of the building on 08/18/21 at 1:15 PM revealed the room lacked emergency lighting. Interview with the Environmental Services Coordinator at the time of the observation indicated there was no battery powered lighting in the room. The code under NFPA 110 (2010 edition) requires "The level I or level II EPS equipment location shall be provided with battery powered emergency lighting in accordance with 7.3.2 requiring the lighting to be supplied on the load side of the transfer switch."	K 918	immediately. (08/25/21) If necessary, ongoing issues will be escalated to the quarterly QAPI meetings and addressed accordingly. (08/25/21) K918 (2) Three emergency lighting fixtures were added to the generator room. (09/09/21) The batteries in the emergency lighting will be added to the monthly preventative maintenance log for testing. (09/09/21) All other emergency lighting coverage was checked during the Life Safety Code survey by the representative of Healthcare Management Solutions, LLC. (08/18/21) Since emergency lighting coverage was checked, and there are no plans to construct any additional areas, this is not considered an ongoing issue. (09/09/21)	

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E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Hawaii, Department of Health, Office of Health Care Assurance on 08/18/21. The facility was found to be in compliance with 42 CFR 483.73.	E 000		

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

Electronically Signed | 09/17/2021

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