STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLANDS SKILLED NURSING & REHABILITATION	1205 ALEXANDER STREET HONOLULU, HI 96826

(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 April 16, 2021. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. One complaint was investigated in the Aspen Complaint Tracking System (ACTS) #8789 and was found not to be substantiated. Survey dates: April 14 to 16, 2021. Survey Census: 29 Sample size: 12	F 000	RECEIVED '21 MAY 19 P4:00 STATE OF HAWAII DOH-OHCA MEDICARE CERTIFICATION	
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in	F 577	F-577 Right to Survey Results/Advocate Agency Info CFR (s):483.10(g)(10)(11) Upon review of violation of right to survey/ advocate agency information, the facility immediately posted the following information in the areas of the facility that are prominent and accessible to the public, patients and residents. The designated areas are located in Resident Activity Area 4th floor, 3rd floor hallway, 2nd floor hallway and 1st floor common area as visitors holding area. The notification information was placed at eye level/ wheelchair The information and contact number for the following: 1.State Survey Agency, the State Licenser office 2.State Long-Term Care Ombudsman 3.Nursing Home Residents Rights Monitoring for Compliance: 1.Receptionist assigned to check weekly for postings and clear view of posters that were delivered by Ombudsman Jomel Dudolao 2.Posting reporting is now part of the QAPI meetings held monthly and quarterly.	04/30/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steven D. L. Mauerhan | TITLE: Administrator | (X6) DATE: 5/14/21

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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F 577	Continued From page 1 areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to post contact information for the State Survey Agency, the State licensure office, and the state Long-Term Care Ombudsman program in a readily accessible place for residents. Findings include: Observation on 04/14/21 at 08:30 AM on the first floor of the entry into facility revealed an electrical advertising board that includes information about the State survey Agency, State licensure office, and State Ombudsman program. During an interview on 04/16/21 at 10:30 AM, the facility agreed the electronic board does not provide information about the State agency and therefore does not meet the needs of many of the resident population who are bedbound and don't move in and out of the facility where they would be able to see the information. Observations made on the 2nd and 3rd floor's on 04/14/21, information on the State Agency, Ombudsman and who to call to file a complaint were not posted in any of the areas where the residents would be able to see the information. Observation and concurrent interview with activities coordinator (AC) on 04/16/21 at 10:00 AM stated that "we are working on putting a board up in activities room to post this information. We are in the process of deciding	F 577		

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F 577	Continued From page 2 where to put the informational board in our activities room.	F 577		
F 578 SS=E	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. (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.	F 578	F578 Request/Refuse/Discntnue Trmnt: Formlte Adv Dir CFR(s):483.10(c)(6)(8)(g)(12)(i)-(v) ISNR was not found to be compliant with F 578 based on observation, interview and record review. There were deficiencies for Advanced Healthcare Directives for two Residents (R)28 and 130. Advanced Healthcare Directives or notes from social worker were not found in electronic chart. ISNR failed to obtain and or offer information on how to formulate an Advanced Healthcare Directive due to previous social worker resigning from company not completing employment agreement. The following corrections have been put in place to address the deficiency: 1. Starting on April 19, 2021 the process was completed / initiated. 2. Newly hired Licensed Social worker (Sang Hae Lee) completed the following: a. Care plan i. Advance Health Care Directive/ POLST (the facility staff will provide resident with information related to his/her right to have POLST and an Advance Directive and what an Advance Directive and POLST are ii. Resident Advanced Directives Wishes will be known iii. Completed / updated Advanced Directives document iv. Review Advanced Directives on file. If applicable	04/19/2021

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F 578	Continued From page 3 (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 observation, interview and record review, the facility failed obtain and/ or offer information on how to formulate an Advanced Healthcare Directive for two Residents (R)28 and 130. Findings include: Record review on 04/15/21 at 11:16 AM no Advanced Healthcare Directives (AHCD) or notes regarding AHCD were found in the electronic chart of Resident's (R)28 and 130. Interview on 04/16/21 at 11:27 AM with Staff(S) 1 who was covering areas for Social worker stated "I've been trying to cover and reach out to the families to provide an AHCD for the residents, when they are admitted." Interview with Director of Nursing (DON) on 04/16/21 at 12:30 PM stated that the social worker for the facility left on April 09, 2021 and a newly hired social worker would be starting on 04/19/21. Upon review of the social service notes found out that there was a lot of information not documented in the records.	F 578	3. The Admissions Director (Lianne Silva) will initiate informing family representative to give a copy of advanced directive on the date of admission. 4. Licensed Social Worker (Sang Hae Lee) will be discussing with the patient/ resident or resident representative importance of giving ISNR the copy of Advanced Health care directive upon admission to better serve the resident rights and wishes for his/her medical and or financial matters. Monitoring for Compliance: 1. Licensed Social Worker (Sang Hae Lee) will double check prior completing care plan on the day of admission 2. Medical Record manager will check the electronic record if the form for advanced healthcare directive is uploaded through PCC (Point Click Care) on the day of admission.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F 585		

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F 585	Continued From page 4 §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her	F 585	F 585 Grievances CFR (s): 483.10(j)(1)-(4) Based on interviews, record review, ISNR failed to meet the requirements. ISNR has immediately made the following changes to be in compliance. 1.Contact information for the State Agency OHCA, LTC Ombudsman, ISNR Grievance Officer have been updated and added to the following: 1. Residents Handbook(addendum) 2. Digital monitor flatscreen displayed on the first floor 3. Contact information provided on the wall by the elevator under the digital flat screen, provide LTC Ombudsman pamphlets on front desk counter, 2nd and 3rd floor hallways posted on the walls at wheelchair eye level. 3. Admissions Packet 2. Additionally, the Residents Concern form was changed to be titled "Resident Grievance/Complaint form" 3.A Grievance folder is located on every floor at the Activities station on the 4th floor, Nurses Station on the 2nd and 3rd floor, Administrators office on the 1st floor. All folders include the updated forms that are titled "Resident Grievance/ Complaint Form" 4. Main Grievance/Complaint Folder will remain with Sang Lee (Director of Social Services) who is the designated Grievance Officer. Administrator will have a copy of the Main Grievance folder which is updated after every morning stand up meeting. SWD will provide copy to Administrator. 5.Investigation training to be provided to Leadership team by Administrator. Use of "Standard" investigation to form to be used with Grievance/Complaint Form	5/05/2021 5/13/2021 5/13/2021 4/19/2021 5/18/2021

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F 585	Continued From page 5 grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;	F 585	CONT.: F 585 Grievances CFR (s): 483.10(j)(1)-(4) 6. Investigation forms will be included with Grievance/Complaint form. Use of "Standard" investigation form to be used in conjunction with Grievance/ Complaint Form in order to provide a more clear and thorough understanding of the situation in order to provide a solution for patient safety, satisfaction and resolution. 7. All Grievance/Complaint forms must be filled in, signed and dated by its entirety by all parties involved including patient, resident or family member. 8. Second page of Grievance/Complaint form for follow up and resolution must also be completed in it's entirety, signed and dated by Administrator, staff, patient, resident or family member after issue is resolved. 9.Additional education and training awareness will be conducted for all staff. Discuss 10.Discuss Grievance/Complaints and investigations every morning at Stand up meetings. 11.Discuss Grievances, complaints and investigation concerns during monthly QAPI meetings. 12. Ensure that all staff understand policy by doing spot checks and team huddles on a WEEKLY basis until Administrator is satisfied that compliance is being met. Results to be discussed in QAPI and Quarterly meetings. concerns during monthly QAPI meetings	5/18/2021 04/19/2021 04/23/2021 04/23/2021

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F 585	Continued From page 6 (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interviews and record review (RR), the facility failed to provide all residents/representatives with the contact information of the grievance official with whom a grievance can be filed and did not provide the contact information of the State Agency (Office of Healthcare Assurance). In addition, the facility failed to respond timely and acknowledge the concern of one Resident's family member (FM) as a grievance, and failed to adequately document thorough investigations of two (R23 and R100) of the four grievances in the sample. Findings include: 1) Review of the "Admission Agreement" included in the admission packet provided the following information regarding the grievance procedure: "When you are admitted we will give you a copy of the Resident's Handbook, which contains our grievance policy. You may also file a complaint with the Long-Term Care Ombudsman. ...Complaints about the care you receive may also be submitted to: Department of Human Service Social Service Division, Adult Protective	F 585	ADMINISTRATOR WILL MONITOR PROGRESS AND HAVE STEWARDSHIP 1.Receive daily report on Grievance/ Complaints during Stand up meeting and require that form is filled out properly, signed and dated. 2.Keep daily log of Grievance/Complaints in two binders which will be found in the SDW Grievance officers office and the Administrators office. 3.Discuss Grievance/Complaints in monthly QAPI meetings. 4.Provide on the spot education and training for any investigations or grievance/complaint forms that are not done properly. 5.Final forms must be signed and dated by all parties including Administrator, Staff, Resident, Patient, Family member. Form will not be accepted unless it is resolved properly. 6.Administrator will randomly follow up with patient, resident or family member to audit the process for successful resolution and that patient is completely satisfied with resolution.	5/13/2021

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F 585	Continued From page 7 Services..." This document did not list the Grievance Officer with contact information or the State Survey Agency, the Office of Healthcare Assurance as an agency to file a grievance. 2) The facility "Resident Handbook" given to all residents on admission provided information how to file a grievance. The handbook read: "Grievance Procedure. ... If a problem should occur, the following grievance procedure is available to you. 1. If you have a problem with a specific department, please address your concern with the Department Head. 2. If you feel the department did not rectify your concern, feel free to contact the administrator. 3. If all attempts at finding a solution fail, the Ombudsman's office is available to act as an intermediary. The Ombudsman can be reached at 586-0100. Occasionally concerns arise after business hours or on weekends. Please contact the nurse manager for completion of a Resolution Action Form so that we may begin to address your concerns as soon as possible. If you request, we will provide you with a written response to your concern." This Handbook did not list the Grievance Officer with contact information and directs residents to notify department heads. The handbook also does not provide contact information for the State Survey Agency, the Office of Healthcare Assurance to file a grievance. 3) Review of the facility policy titled "Grievances/Complaints, Recording and Investigating (undated)," revealed the following implantation steps: "... 2. Upon receiving a grievance and complaint report, the Grievance Officer will begin an investigation into the	F 585		

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F 585	Continued From page 8 allegations. 3. The department director(s) of any named employees will be notified of the nature of the complaint and that an investigation is underway. ... 5. The Grievance Officer will record and maintain all grievances and complaints on the "Resident Grievance Complaint Log." The following information will be recorded and maintained in the log: ... f. The date the resident, or interested party, was informed of the findings, and g. The disposition of the grievance. ... 9. A copy of the "Resident Grievance/Complaint Investigation Report Form" must be attached to the "Resident Grievance/Complaint Form." 4) The facility policy titled "Grievances/Complaints, Filing (undated)" stated: "The contact information for the individual(s) with whom a grievance may be filed is provided to the resident and/or representative upon admission. 7. The Administrator has delegated the responsibility of grievance and/or complaint investigation to the Grievance Officer who is Social Work Director (SWD) and can be contacted at ... 12. The resident, or person filing the grievance and/or complaint will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems." 5) On 04/16/21 reviewed the documentation of the four complaints/grievances listed on the grievance log since September 2020. All four were documented on a form titled "Resident Concern or Request Form" dated July 2011. There were no forms titled Resident Grievance/Complaint Form, Resident Grievance/Complaint Investigation Form or Resolution Action Form as referenced in the policies/documents.	F 585		

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F 585	Continued From page 9	F 585		

6) Review of the grievance documentation on 04/16/21 revealed the following:

On 09/13/20 Resident(R)100 filed the concern: "2 female CNA's (certified nurse assistants) touching resident inappropriately. Reason or cause for the occurrence: CNA was checking if resident was soiled. Suggestion(s) or Recommendation(s) for Resolution: Per resident do not assign the CNA's to her. Immediate Action Taken: Notified DON had CNA reassigned. ...Department(s) responsible for Follow-up: Nursing." The form was signed by the Social services director (SSD). There were two CNA's referenced in this complaint, yet there is no documentation of their account of the incident except "CNA was checking if resident was soiled," which was written by the SWD. There was lack of documentation of a thorough investigation by nursing, and no follow up post incident with R100.

On 02/20/21 R101 filed a concern about two CNA's turning/changing position without asking permission first and "food concerns." There was documentation of follow up with the CNA's and a diet requisition was sent. The form has a designated area for "follow up with Resident (Approximately 2 weeks...)" with an area for Resident and Staff signatures with date. The comment "Food concerns & mattress concerns resolved" was written in this space. There was no notation regarding the positioning or signatures of R101 or staff who wrote the comment.

On 04/08/21 R23 filed the concern that "During toilet use, CNA pull onf [sic] brief hard not careful that the pain radiates to the entire body." The

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F 585	Continued From page 10 recommendation was to "Investigate and interview staff involved." There was no documentation of any investigation or interviews. The CNA was put on administrative leave and responsibility for follow up was assigned to the Nursing Department & Social Services Director (SSD). The plan for resolution was the "CNA will not be schedule [sic] to work in second floor." There was no additional documentation of the investigation, status of the CNA or follow up with R23. On 04/13/21 A Family Member (FM) of a Resident that had been at the facility contacted the Office of Healthcare Assurance regarding concerns and that the facility had not responded to verbalized concerns in a timely manner. The FM said he/she had spoken to several individuals and was told the SWD would call back. This concern was not listed on the grievance log and the SWD was no longer employed at the facility for further follow up. On 04/15/21 at 17:00 during an interview with the Director of Nursing (DON), she said the CNA referenced in the 04/08/21 complaint had been terminated. At that time, inquired if the facility provided a written summary of investigation findings to the resident/representative as outlined in the policy and she said they do not.	F 585		
F 623 SS=E	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	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 11 the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F 623		

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F 623	Continued From page 12 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623	F-623 SS=E Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) Upon review, ISNR was not found to be compliant. The following corrections have been put in place to address the deficiency: 1.Starting on April 19, 2021 a discharge / transfer notice was initiated. The notice was (confidentially) faxed to John G. McDermott (john.mcdermott@doh.hawaii.gov) Fax 808-586-0185, Phone number for work 808-586-7268. Hawaii State Long Term Care Ombudsman (see sample) 2.Licensed Social Worker (Sang Hae Lee) is a designated person who will email, fax and mail the notice of discharged and transfer to Ombudsman LTC. 3.A similar form of a discharge / transfer notice will be mailed to residents and resident's representative. 4.The following included in the notice are: a. Name of sender b. Phone number of sender (SWL) San Lee c. Name of facility d. Name of resident e. Date of admission f. Resident contact info (room #, Phone #) g. Name of family / Representative h. Family contact info (phone #, Address) i. Reason for discharge j. Date of discharge notice given k. Date of schedule discharge l. Discharge to where? m. Transportation provided by who? n. Resident agrees with discharge? Yes or No o. Family or POA agrees with discharge? Yes or No p. What support services have been / will be ordered?	04/19/2021

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F 623	Continued From page 13 §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 (RR) and interview, the facility did not have a process in place to notify the resident and the resident's representative of a transfer in writing and additionally did not send a copy of the notice to the Long Term Care (LTC) Ombudsman. As a result of this deficiency, the residents do not have the added protection and advocacy of the Ombudsman's office to monitor for the potential of inappropriate transfers/discharges. Findings include: 1) RR of facility initiated transfers revealed two Residents(R)3 and R103) medical records did not contain documentation of notice to the Ombudsman. 2) On 04/15/21 at approximately 05:15 PM during an interview with the Director of Nursing, she said the facility does not notify the Ombudsman of facility initiated transfers to the hospital and do not provide the resident/representative a written notice with reasons for the move.	F 623	q. Medications reconciled? Yes or No r. Medication ordered? Yes or No s. Assistive devices ordered? Yes or No t. Any home modification needed? Yes or No u. Was health plan involved / notified of discharge? Yes or No v. Additional details: _____ Monitoring compliance: 1.The notice of transfer / discharge will be emailed to LTC Ombudsman, directors (discharge team) one week in advance or few days prior of discharge date. 2.Medical Record Manager will follow up with Resident or Resident's rep for receipt of notice of transfer/discharge.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)	F 638		

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F 638	Continued From page 14 §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on Record review and interview, the facility failed to complete the most recent resident quarterly assessment for one Resident (R)2 within the 90 day requirement. The deficient practice has the potential to affect the quality of the Resident's care. Findings include: Surveyor reviewed the electronic medical record (EMR) for R2 on 04/16/21 at 09:38 AM, and noted that the most recent minimum data set (MDS) quarterly assessment was completed on 03/31/21. The previous assessment was completed on 11/24/20, indicating the 03/31/21 quarterly assessment was late. The 03/31/21 assessment was due by 02/28/21. Surveyor interviewed the MDS coordinator on 04/16/21 at 10:00 AM. When asked if the MDS quarterly assessment dated 03/31/21 for R2 was completed past the 90 day requirement, the MDS coordinator looked at R2's MDS in the EMR and stated "It got missed, it was late".	F 638	F-638- - SS=D Qrtly Assessment at Least Every 3 months CFR)s): 483.20(c) Based on the facility review of the violations of Quarterly Review Assessment (Minimum Data Set), ISNR did not meet the requirement to report the Quarterly Assessment of MDS on time to CMS (Center of Medicaid and Medicare Services). The MDS coordinator missed and completed late the electronic medical record for R2. The following corrections have been put in place to address the deficiency: 1. Will address and set the next ARD for quarterly, Annual or any significant change as soon as current MDS is completed. 2. MDS coordinator will do a week of advance check for all assessments of ARD (assessment reference date) that are due for the following week. Monitoring Compliance: 1. DON (Director of Nursing/MDS certified) will check randomly on weekly basis for all Quarterly Assessment for the ICF (Intermediate level of Care Facility) residents. 2. MDS coordinator will report to DON for all weekly check list for upcoming ARD assessments.	04 21 2021
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,	F 697		

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F 697	Continued From page 15 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 that the pain management provided for Resident (R)130 is consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goal and preferences. The deficient practice affected the residents psychological and physical well being. Findings include: Observation and interview done on 04/14/21 at 09:30 AM with R130 at bedside. R130 tearful and stating that her pain usually improves with Oxycodone, and that she is "so uncomfortable". R130 asked this surveyor to move her leg. Certified nursing assistant (CNA)1 came in and repositioned R130. Observation on 04/15/21 at 06:44 AM with R130, who appeared anxious and with pain. Queried R130 who said she was in a lot of pain. R130 stated that Oxycodone "works sometimes." Observation on 04/15/21 at 09:15 AM with R130 who was teary-eyed, and stated she is uncomfortable and in pain. She asked this surveyor to call the nurse. At 09:20 AM, interview with registered nurse (RN)1. RN1 stated that she gave Tylenol this morning and said that night shift gave pain medications. RN1 explained that she will be calling the doctor for a stronger regimen.	F 697	F 697 SS=D Pain Management CFR(s)483.2(k) Upon review of the following violations, ISNR failed to ensure appropriate interventions to relieve discomfort pain to R130. Facility will conduct the following interventions to ensure the facility is compliant: 1. Huddle staff (4-20-2021) how to report pain immediately to licensed staff to relieve the pain as soon as possible. 2. Huddle Nursing staff to be aware of patient centered care plan and appropriate interventions 3. Pain Management was included on QAPI discussion 4. Admission pain assessment, base line care plan pain assessment, weekly pain assessment will be discussed and monitored. 5. Ronald Carlos RN will be the pain management chairman(chairperson). Ronald will audit, conduct and review all pain issues on a weekly basis. Will be recorded and time stamped in PointClickCare. Monitoring compliance: 1. DON (Director of Nursing) weekly routine check with pain management chairperson (Ronald RN), including interventions, medications, patient outcomes, and patient centered care plan for completions. 2. Chairperson will randomly conduct on weekly basis for all patients with high intolerance of pain. Report and revision of care plan will be included on weekly basis to address pain relief with main provider involvement 3. Weekly patient centered care plan will be reviewed by DON and pain management chairperson.	5/09/2021

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F 697	Continued From page 16	F 697		

Record Review (RR) on 04/15/21 at 12:00 PM showed pain level summary with a date of 04/15/2021 at 08:00 AM with a value of 3/10. The next documented pain level summary value at 11:37 AM was 0. No pain level value was documented after 11:37 AM although R130 complained of pain at 09:15 AM earlier and was teary eyed with this surveyor.

Observation and interview on 04/16/21 at 09:50 AM with R130. R130 reported she was having pain at 8/10, uncomfortable and not able to speak because of pain.

RR showed that on 04/16/21, R130 received one 5 mg tablet of Oxycodone, although she can have (2 tablets) by mouth as needed for pain related to unspecified injury at unspecified level of cervical spinal cord, at 00:41 AM. At 05:00 AM, R130 got Oxycodone 5 mg. (one tablet) by mouth every four hours as needed for moderate pain. R130 also received 2 tablets of Acetaminophen 375 tablet by mouth at 05:00 AM on 04/16/21. Pain level summary value was documented on 04/16/21 at a value of 7 at 05:00 AM. RR pain level summary on 04/16/21 at 09:52 AM showed a value of 8/10.

Interview on 04/16/21 at 10:00 AM at the bedside with RN2. Informed RN2 of R130's pain. RN2 stated that she gave R130 Pregabalin this am. Surveyor asked RN2 if she had re-assessed R130's pain level since giving the Pregabalin, RN2 responded that the resident can get Oxycodone. RN2 was not able to answer that she re-assessed R130 for pain. R130's pain level was not assessed from 05:00 AM until 09:52 AM.

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F 741 SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents 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 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 §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews (RR) the facility failed to provide sufficient staff who possess the basic competencies and skills set to meet the behavioral health needs of the residents. The facility Social Services Director (SSD) failed to provide adequate follow up on two Residents (R)3 and R130 who had	F 741	F 741 Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) ISNR was not found to be compliant with F741 based on observation, interview and record review. ISNR was not able to provide sufficient competent care after the unexpected departure of our Dir. Social Services. Therefore ISNR will immediately do the following in preparation for any future challenges: 1.Assure that there is proper coverage in case of sudden loss of Director of Social Services by contracting with Temp Social Work agency. www.tempsocialwork.com. Temp. agent Melanie Sutton. Contract completed. 2.In the process of hiring an additional Social Services Assistant. (Poliahu Kaumatule) for additional coverage to provide overlap and continuity of care to meet the behavioral health needs of the residents. 3.The additional Social Services staff member and contract with Temp Social Services will allow for ISNR to be compliant and provide appropriate social services in order to maintain resident safety, attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. 4. Continued Monitoring of Staff Needs will be assessed by the Administrator. 5. Social Services staffing, education and contingency plans will be addressed in monthly QAPI meetings.	04/19/2021 05/13/2021

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F 741	Continued From page 18 behavioral health needs. The investigation revealed the facility did not have a Social Worker on staff to do initial psychosocial assessments on new admissions or provide ongoing services to current residents from 04/10/21 until the new Social Worker would start (projected date 04/18/21). As a result of this deficiency, the new and current Residents did not get the services needed to meet their psychological needs and to reach and maintain their highest practicable well-being. Findings include: 1) Interview with R130 on 04/15/21 at 06:46 AM revealed a sad, teary eyed, worried 69 year/old female exhibiting distressed behaviors. R130 verbalized she was uncertain of her future and she can't think. She appeared worried and wanted to go home. R130 was not able to move her legs but moves her arms up slowly and down. Hands were clenched to a soft fist. Presents with a cervical collar on. Has bruises to her face. R130 briefly stated that she blacked out at home and does not remember what happened. Her boyfriend found her. R130 also was exhibiting pain and felt uncomfortable. On 04/16/21 at 11:30 AM, R130 still had not been assessed for social service needs to meet her psychological needs. Record Review (RR) confirmed no progress notes for Social services. Interview with Director of Nursing (DON) on 04/16/21 at 12:30 PM stated that the social worker for the facility left on April 09, 2021 and a newly hired social worker would be starting on 04/19/21. Upon review of the social service notes found out that there was a lot of information	F 741		

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F 741	Continued From page 19 not documented in the resident records. 2) R3 is a 32 year old male with history of Cerebral Vascula Attack (CVA) that resulted in chronic respiratory failure and was tracheostomy dependant. He was a functional quadriplegia, had increased secretions that required frequent suctioning, dysphasia (difficulty swallowing), had an indwelling Foley catheter. R3 received all his nutrition through a PEG tube inserted in his abdomen. Due to his acute life change R3 took two medications for his depression, Lexapro and Seroquel. He displayed decreased motivation for Physical and Occupational Therapy (PT/OT), refused Speech Therapy (ST) and had episodes of refusing care. RR of R3's Social Services (SS) progress notes revealed entries for February: 02/03/21, 02/05/12, 02/11/21, 02/18/21, 02/22/21, 02/25/21. The progress note on 02/25/21 included: "ST DC (discontinued) due to lack of participation and resident requested DC. ...Due to decreased motivation PT/OT tent (tentatively) DC 3/24. Family visit 2/22 to boost moral and encourage. Episodes of resident refusing care, psych (psychiatric) consult scheduled for 3/24..." There were two SS progress note entries in March, 03/05/21 and 03/11/21 with no new information. There was no SS progress notes after 03/11/21 or documentation that the SWD had contact with or provided services to R3. On 04/15/21 at approximately 02:00 PM during an interview with the Director of Nursing (DON), she confirmed there were no SS progress notes after 03/11/21 and said she was unaware the notes were not being done. The DON went on to say the SSD's last day at the facility was "last Friday (04/09/21)."	F 741		

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	125067	A. BUILDING 01 - MAIN BUILDING B. WING _____	08/17/2021

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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 17, 2021. The Facility was found not to be in compliance with the requirements of 42 CFR 483.90. The facility is a four-story building. The fourth floor is therapy and dining and kitchen services, the second and third floors are skilled nursing services, and the first floor is administrative and laundry. The facility was constructed in early 1960's of concrete roofing, concrete flooring and concrete bearing walls. The facility has a 60 KW diesel generator that supplies back up power to the entire building.	K 000	RECEIVED '22 APR -4 A9:19 STATE OF HAWAII DOH-OHCA MEDICARE CERTIFICATION	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, review of fire alarm reports, and interview with the facility Maintenance Director, the facility failed to ensure that smoke detectors were inspected and tested in accordance with NFPA 72 (2010 edition) sections 14.4.5.3.2 and table 14.4.2.2. This deficient practice had the potential to affect all 26	K 345	Islands SN&R is committed to ensure that smoke detection sensitivity will be conducted/performed. Systems Engineering Group (SEG) was contracted and performed the smoke detector sensitivity testing on 8/19/2021 and every 2 years henceforth. (See attached) Training was conducted for maintenance staff regarding timely scheduling of detector sensitivity testing and maintenance of smoke detection system and to check facility Tels Inspection System for all scheduled maintenance/requirements. Weekly/frequent audits will be conducted and documented by Maintenance Director to ensure that all scheduled tasks are performed as indicated/required and documented.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Steven D. de Mauriac	Administrator	3/1/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING 01 - MAIN BUILDING B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLANDS SKILLED NURSING & REHABILITATION	1205 ALEXANDER STREET HONOLULU, HI 96826

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K 345	Continued From page 1 residents in the facility. Findings include: Observation on 08/17/21 at 9:50 AM revealed smoke detectors are hard wired in all corridors and open use areas. Record review of the most recent fire alarm inspection reports dated 01/25/21 and 11/25/19 revealed the reports did not address smoke detection sensitivity in the past two years. During an interview on 08/17/21 at 10:50 AM, the Maintenance Director stated there is no documentation that the smoke detectors were tested for sensitivity. The Maintenance Director called the fire alarm system testing company to request a smoke detection sensitivity report. As of the exit conference, the smoke detection sensitivity report is not available. The code at NFPA 72 (2010 edition) section 14.4.5.3.2 requires, "Sensitivity shall be checked every alternate year unless otherwise permitted." The code also requires annual testing of the smoke detection system and bi-annual visual inspections of the smoke detection system according to NFPA 72 (2010 edition) table 14.4.2.2.	K 345	Maintenance Director will assure that smoke detector sensitivity monitoring will be conducted every 2 years or sooner as necessary by a licensed contractor and assure documentation of the range of the detector and reading. Detectors not within limits shall be replaced promptly. Ongoing monitoring and evaluation will be conducted by Maintenance Director and Administrator to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA meetings. (11/3/2021)	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		

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K 353	Continued From page 2 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on review of the sprinkler contractor report and interview with the facility Maintenance Director, the facility failed to test and maintain the sprinkler system in accordance with NFPA 25 table 5.1.1.2. This deficient practice had the potential to affect all 26 residents in the facility. Findings include: Review of the facility sprinkler system report titled, "Elite Fire Service Sprinkler Inspection" dated 12/28/20 revealed the facility had one annual sprinkler system inspection in the past twelve months. During an Interview on 08/17/21 at 11:15 AM, the Maintenance Director stated he/she does not have any quarterly sprinkler reports. In addition, due to the lack of quarterly sprinkler inspections, the facility electronic tamper switches and waterflow switches have not been checked as required.	K 353	Islands SN&R is committed to ensure ongoing maintenance and testing of the sprinkler system. On 9/17/2021, quarterly inspection for the sprinkler system was conducted by Honolulu Fire Protection which included inspection of water flow alarms, other alarms associated with sprinkler systems and all supervisor alarms on the sprinkler system. Quarterly monitoring and inspection shall be conducted by contractor Honolulu Fire Protection per our signed contract. Training was conducted for maintenance staff on the importance of checking the facility Tels Inspection System and perform all tasks that are due timely and that sprinkler tests are conducted quarterly and documented. Weekly/frequent audits will be conducted and documented by Maintenance Director to ensure that all scheduled tasks are performed as indicated/required and documented. Ongoing monitoring and evaluation will be conducted by Maintenance Director and Administrator to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA meetings. (11/3/2021)	

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K 353	Continued From page 3 The code under NFPA 25 table 5.1.1.2 requires an inspection to be completed of the waterflow device, alarm devices associated with the sprinkler system, and the valve supervisory system devices on a quarterly basis. The annual inspections are to include bracing inspections, pipes and fittings, and all sprinkler heads in addition to what is required on the quarterly inspections.	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the	K 363	Islands SN&R is committed to ensure that doors of resident rooms are without impediments to closing. Contents of resident rooms were removed and/or reorganized to accommodate maximum usage of room space and allow easier access within the rooms and assures that resident room door areas are clear. No impediments will be used to prevent closure of resident room door. Training was conducted for all staff regarding the discontinuation of use of impediments to closing of resident room doors, removal of excess furniture and reorganization of rooms was conducted for easier access and eliminates need for keeping doors open and informed of the potential for harm occurring with continued use of impediments.	

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K 363	Continued From page 4 smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview with the facility Maintenance Director, the facility failed to ensure nine of 18 bedrooms doors were without impediments to closing in accordance with NFPA 101 (2012 edition) section 19.3.6.3.10. This deficient practice had the potential to place the 14 residents in the nine rooms at risk of harm. Findings include: Observations on 08/17/21 from 9:15 AM to 10:15 AM revealed bedroom doors 201, 203, 204, 205, 301, 303, 304, 305, and 306 had impediments to closing the door. The bed in each case was an impediment to closing the corridor bedroom door. Interview with the Maintenance Director at the time of the observations verified that the doors each had an impediment which did not allow the door to close without significant effort which would involve moving the bed or beds in the room. The code requires under NFPA 101 (2012 edition) section 19.3.6.3.10 that "doors shall not be held open by devices other than those that release	K 363	Daily audits will be conducted and documented by Maintenance Director to ensure that no use of impediments to closing resident room doors will be used, doorways are clear and ensure proper resident room door closure. Ongoing monitoring and evaluation will be conducted by Maintenance Director and Administrator to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA meetings. (11/3/2021)	

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K 363	Continued From page 5 when the door is pushed or pulled."	K 363		
K 364 SS=F	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observations and interview with the facility Maintenance Director, the facility failed to ensure two walls on two floors did not have transfer grills allowing the passage of smoke and fire into the exit access corridor in accordance with NFPA 101 (2012 edition) section 8.3.4.1. This had the potential to affect all 26 residents on both floors. Findings include: Observations of the third-floor medication room from the corridor on 08/17/21 at 9:25 AM revealed a transfer grill above the door between	K 364	Islands SN&R is committed to ensure that transfer grilles are not used in corridor walls or doors. The grille and damper will be removed and sealed with double 5/8 rated drywall by Pat Torres (Director of Maintenance) Completion dated 12/13/2021. Training of maintenance staff was conducted to ensure that transfer grills are not to be installed on corridor walls or doors and the potential for harm of continued use. Weekly/frequent audits will be conducted and documented by Maintenance Director to ensure that walls and/or doors do not have transfer grills installed. Ongoing monitoring and evaluation will be conducted by Maintenance Director and Administrator to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA meetings. (12/13/2021)	

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K 364	Continued From page 6 the main exit access corridor and the medication room. The transfer grill measured 36 inches wide by 8 inches high. Interview with the Maintenance Director at the time of the observation indicated the transfer grill was installed to vent the room's hot air from the pharmacy machine. He also indicated the opening lacks a fire or smoke damper which would automatically close off the opening in the event of the activation of the fire alarm or sprinkler system. Observations of the second-floor storage room from the corridor labeled "medication room" on 08/17/21 at 9:50 AM revealed a transfer grill from the room above the door to the main exit access corridor. The transfer grill measured 36 inches wide by 8 inches high. Interview with the Maintenance Director at the time of the observation indicated the transfer grill was installed to vent the room's hot air from the pharmacy machine, however, at this time, the room is used for medical storage. No pharmacy machine was present. He also indicated the opening lacks a fire or smoke damper which would automatically close off the opening in the event of the activation of the fire alarm or sprinkler system. The code requires under NFPA 101 (2012 edition) section 8.3.4.1 that "every opening in a fire barrier shall be protected to limit the spread of smoke and fire movement from the one side of the barrier to the other side. "	K 364		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		

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K 918	Continued From page 7 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in 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 with the Maintenance Director, the	K 918	Islands SN&R is committed to ensure that facility essential electrical system maintenance is in compliance. Hawthorne CAT, contracted vendor with ISNR completed their Load Bank Test on 10/22/2021. Load Bank Sheet was sent in previously in November. Training of maintenance staff was conducted regarding essential electric systems and requirements and the importance of conducting weekly/ monthly generator checks as per requirements. Weekly/frequent audits will be conducted and documented by Maintenance Director to ensure that facility electrical systems are in compliance. Ongoing monitoring and evaluation will be conducted by Maintenance Director and Administrator to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA meetings. I0/23/2021	

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K 918	Continued From page 8 facility failed to ensure its 60 Kilowatts (KW) diesel generator was maintained in accordance with NFPA 110 (2010 edition) section 17.3.4.3. by failing to conduct a load bank test. This had the potential to affect all 26 residents. Findings include: Observation on 08/17/21 at 9:15 AM revealed the facility has a 60-kilowatt (KW) diesel generator located on the roof. Review of the facility generator contractor documentation located in the fire safety binder dated 06/25/21 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. Interview with the Maintenance Director at the time of the review revealed he does not have a load bank test and will contact the contractor. The code requires under NFPA 110 (2010 edition) section 7-13.4.3. that "a load test shall be applied for 2 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]."	K 918		