STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125014	A. BUILDING _____ B. WING _____	02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA RETIREMENT RESIDENCE	1434 PUNAHOU STREET HONOLULU, HI 96822

(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 Health Care Assurance (OHCA). The facility was found not to be in substantial compliance with 42 CFR 483 Subpart B. One Facility Reported Incidents (FRI) from the Aspen Complaints/Incidents Tracking System (ACTS) #9270 was found unsubstantiated. Survey Dates: February 15, 2022 to February 18, 2021. Survey Census: 61 Sample Size: 17	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 688		3/11/22

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

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F 688	Continued From page 1 Based on observation, interview and record review, the facility failed to provide that appropriate treatment and services for 1 out of 2 sampled residents R(55) to increase ROM and/or to prevent further decrease in range of motion and maintain and/or improve physical functioning. Findings include: During an interview on 02/15/22 at 12:25 PM , the R55 stated that she had blisters on her buttocks and the nurse stated that it is from the sheets caused by friction. R55 further stated that she does not get out of bed and that she had physical therapy at home. She does not know if she will get physical therapy in the facility. Record review (RR) done on 02/15/22 shows an 84-year-old female admitted from home to facility for 24-hour nursing care with activities of daily living assistance and mobility. R55 was diagnosed with a history of stroke and left sided weakness and admitted to the facility on 04/21/21. Care plan report dated 04/27/21 interventions states contracture of muscle-left upper arm OT 2x period in 60 days-resident would like to maintain current ROM and decrease risk of increased contractures. Refer to OT POC and rehab notes. Due to insurance coverage and resident not willing to private pay services, only OT eval done. No further treatment needed at this time. Will continue to monitor contracture to left shoulder. Care plan report dated 05/27/2021 interventions states to provide extensive assistance with 1-2-man support with bed mobility, transfers, total assist with locomotion with wheelchair to reach destination in her room with 1 person support. Record review (RR) done on 02/15/22 of care	F 688	On 2/28/22, Director of CNA Services discussed with R55 current routine for ADLs and an out of bed routine to maintain R55□'s range of motion. R55 agreed to participate to get out of bed on Tuesdays and Thursdays to start and increase as tolerated, Care Plan updated as of 3/10/22. R55 was also seen by OT and Wellness manager to provide Passive Range of Motion training and established a routine for R55.(See attached ROM training logs) The facility identified other residents having the potential to be affected by the same deficient practice by reviewing all residents at risk for decline of range of motion. Audit was completed by 3/11/22 to ensure care plan incorporated therapy, Wellness range of motion program and/or out of bed routine. Measures and systemic changes that will be implemented to ensure this deficient practice does not recur by identifying residents during utilization review meeting to determine that if a personalized plan is not able to be established with therapy, then an alternative or general range of motion program can be established and care planned. The Facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur by tracking residents discussed in utilization review that have an alternative or general range of motion program and/or	

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F 688	Continued From page 2	F 688		

plan entry date of 08/15/21 states R55 had difficulty transferring requiring 3-4-man support from bed to shower chair.

Record review (RR) done on 02/15/22 of care plan entry dated 08/18/21 shows Physical therapy (PT) evaluation completed. PT eval only. PT recommended to use only Hoyer lift for transfer due to staff/resident concerns safety.

Observation and concurrent interview made on 02/15/22 at 02:30 PM with R55 shows resident in bed. R55 stated that she did not get out of bed today.

Observation and concurrent interview made on 02/16/22 at 10:00 AM with R55 shows resident in bed. R55 stated she did not get out of bed today.

Observation and concurrent interview made on 02/17/22 at 09:00 AM with R55 shows resident in bed. R55 stated she did not get out of bed today. She does not know if she will get physical therapy.

Interview on 02/18/22 at 12:49 PM 02/18/22 12:49 PM with the administrator was done. Surveyor queried why resident was only receiving PT and OT evaluations and not treatment. Queried also why resident was not getting out of bed with Hoyer lift. Administrator stated that R55 would need to get therapy outside and if she wanted it here, her insurance doesn't cover part B for inpatient services. We did do some evaluation and plan of care, but her insurance plan doesn't cover it. Before the outbreak, we were getting a supplemental plan but that takes guidance for therapy. We also looked at her changing her insurance plan, but she must wait

decreased mobility or range of motion and present findings in QAPI and QA Programs.

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F 688	Continued From page 3 for the enrollment plan if changing her insurance as well. Although the facility had done an OT and PT evaluations, R55 was not able to receive treatment due to lack of insurance. During R55's stay, she has not been getting out of bed and has blisters on her buttocks. R55 further stated she requires a Hoyer lift. Documentation states that at times, R55 requires 4-5 staff to get her out of the bed. R55 states that she sometimes gets range of motion in the morning. R55 was admitted with limited range of motion and is not receiving the appropriate treatment and services to increase or prevent further decrease in range of motion.	F 688		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758		3/11/22

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F 758	Continued From page 4 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record reviews, the facility did not ensure that the residents are free from unnecessary medications for 1 of 17 sampled residents (R10). The facility failed to identify and consistently monitor behaviors and side effects for the residents. These failures had the potential to prevent Residents from attaining their highest practicable level of mental, physical and psychosocial well-being.	F 758	R10's current behavior documentation, consultation of pharmacist and tracking of behavior, indicated the continued use of escitalopram 5 mg. The Facility followed up with R10's PCP on 3/11/22 to discontinue tracking of target behavior - sadness and to continue to monitoring for agitation and restlessness. The Facility will continue to monitor R10'□s Behavior	

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F 758	Continued From page 5 Findings include: R10 was admitted to the facility on 09/28/18 with several diagnoses including history of transient ischemic attack (TIA), and cerebral infarction without resident deficits, Alzheimer's dementia with episodes of increased confusion and has balance problems with weakness. R10 was recently diagnosed with depression and started on an antidepressant. Review of the psychotropic meeting progress notes dated 10/20/21 revealed that the resident was started on Escitalopram 50 mg every day on 07/15/21 for depression with target behaviors of sadness and poor food intake. Review of the medication administration record (MAR) revealed that the resident had been receiving the antidepressant drug as ordered. Review of the behavior monitor/intervention flow record for the month of July failed to identify and document the behavior of sadness for the use of an antidepressant medication from the start and ongoing through August the need for use of an antidepressant medication. In an interview on 02/18/22 at 02:16 PM with the Director of Nursing and Administrator, the lack of documentation regarding the antidepressant was discussed and acknowledged. Without adequate behavior monitoring as well as monitoring for adverse effects, the antidepressant is deemed an unnecessary drug.	F 758	Flow Record and perform a GDR if/when indicated. The Facility identified other residents having the potential to be affected by the same deficient practice by performing a 100% audit by 3/11/22. Residents on psychotropic medications were audited to ensure documentation of medication, orders and target behaviors were indicated and appropriate. Measures and systemic changes that will be implemented to ensure this deficient practice does not recur by In-servicing licensed staff on appropriate documentation of behaviors using Behavior Flow sheet, monitoring and updating when indicated by 3/11/22. Findings will be reviewed by the Psychotropic/Behavior Committee with collaboration of Medical Director and Consultant Pharmacist who will continue to review the records monthly to make recommendation(s) for GDR, if indicated. Starting 3/11/22, audits on new or changed psychotropic medication will be conducted by Licensed Social Worker, Director of Nursing or designee to review the medication, target behavior and documentation (behavior flow record is executed). The Facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur by presenting any findings from the	

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F 758	Continued From page 6	F 758	Psychotropic/Behavior Committee with collaboration of Medical Director and Consultant Pharmacist. Any fluctuations in residents□ behaviors will be tracked and trended through the Psychotropic/Behavior Committee and will be reported through the Facility'□s QA program.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		3/11/22

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F 880	Continued From page 7 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility	F 880	The identified bags of soiled cleaning	

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F 880	Continued From page 8 failed to store soiled laundry in closed plastic bags and off the floor of the laundry room. As a result of this deficient practice, the facility was put at potential risk for spread of infection. Findings Include: On 02/17/22 at 06:30 AM in the first-floor laundry room, surveyor observed two opened black plastic trash bags on the ground next to the sink. The two plastic bags were full of dirty cleaning towels. A commercial laundry washer next to sink was labeled with a sign that stated, "Out of order. Do not use." A smaller washing machine was turned on and running. On 2/17/22 at 02:13 PM in the first-floor laundry room, surveyor observed ten black plastic trash bags on the ground next to the sink and washing machine. The ten bags were opened and were full of dirty cleaning towels. There was a small luggage cart with no side walls. Three closed plastic bags were stacked in the cart and took up half of the space in the cart. On 02/17/22 at 2:13 PM, Housekeeping Supervisor (HS) was interviewed in the 1st floor laundry room. HS stated, "The plastic bags should be closed and not opened. We only have this cart for bringing down the laundry. The cart cannot hold a lot of bags. Our main washer broke last week so we had to bring down a smaller laundry machine to wash all of this laundry until it can get fixed." On 2/18/22 at 06:27 AM at the first-floor laundry room, surveyor observed two opened plastic bags on the ground next to the sink. The two plastic bags were full of dirty cleaning towels.	F 880	towels were addressed on 2/17/22 and 2/18/22 by the housekeeping supervisor. All residents in the health care center had the potential to be affected by the deficient practice. Measures and systemic changes that will be implemented to ensure this deficient practice does not recur by adjusting storage process of soiled linen to utilize covered bins for storage. (see attached bins) In-service was conducted by 3/11/22 for housekeeping staff on the new process for storage and handling of soiled cleaning towels. (See attached in-service records) The Facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur by conducting random weekly audits by housekeeping supervisor or designee to visually check bins and laundry areas and report any significant findings through QAPI/QA.	

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F 880	Continued From page 9 On 02/18/22 at 06:45 AM, HS was interviewed on the second floor. HS stated, "I just saw the two opened bags of dirty laundry downstairs and tied them closed. I told staff the bags need to be closed." On 02/18/22 at 08:54 AM, Infection Preventionist (IP) was interviewed in the second floor IP office. IP stated, "Bags with dirty laundry should be tied closed and stored off of the ground."	F 880		

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E 000	Initial Comments A recertification survey was conducted by the Office of Health Care Assurance on February 15, 2022 through February 18, 2022. The facility was found to be in substantial compliance with §483.73, Requirement for Long-Term Care (LTC) Facilities of Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual.	E 000		

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

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	125014	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/16/2022**

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K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: K-223 Doors with self-closing devices This STANDARD is not met as evidenced by: Based on observation and staff interview with the maintenance director, the facility failed to ensure that the hazardous area door for the soiled linen room was equipped with a self-closing device. This observation of the missing door self-closing device is not in accordance with the 2012 edition of the NFPA 101 Life Safety Code, section 7.2.1.8.1. This deficient practice could affect all residents, staff, and visitors if smoke and fire was to move from these areas into the exit corridor. Findings include: An observation on 2/16/22 at approximately 12:30 pm revealed the soiled linen storage room was not equipped with a self-closing device. These findings were verified at the exit conference with the maintenance director and Administrator on 2/16/22 at 2:15 pm.	K 223	The linen room door identified was addressed on 3/3/22 and self-closing device was installed. All residents, staff and visitors in the health care center had the potential to be affected by the deficient practice. Measures and systemic changes that will be implemented to ensure this deficient practice does not recur by installing self-closing device on linen door. The Facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur by including linen room door to facility'□s annual fire door inspection which includes inspection of self-closing devices. (see attached door picture and annual	3/3/22

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K 223	Continued From page 1	K 223	inspection checklist)	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: K-291 Emergency Lighting This STANDARD is not met as evidenced by: Based on record review with staff members, the facility failed to test and maintain the emergency lighting with a 90 minute annual inspection and testing in accordance with NFPA 101, Life Safety Code, 2012 edition, section 7.9.3.1.1. This deficiency could affect all residents, staff, and visitors during an emergency requiring evacuation from the facility. Findings include: During facility survey on 2/16/22 at approximately 1:30 pm, revealed that the facility failed to conduct an annual 90 minute exit light function test. The light provides lighting for the exit stairway serving all occupants of the building. These findings were verified at the exit conference with the facility manager and Administrator on 2/16/22 at 2:15 pm.	K 291	The identified redundant back-up emergency lighting was assessed and tested on 3/2/22 for required 90 minute testing. All issues identified during the 90 minute testing was addressed with contractor on 3/4/22.(See attached checklist) All residents, staff and visitors in the health care center had the potential to be affected by the deficient practice. Measures and systemic changes that will be implemented to ensure this deficient practice does not recur include annual testing of emergency lighting for 90 minutes to ensure lights are functioning appropriately and address any finding(s) with appropriate contractor. The Facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur by reviewing results of the annual inspections for the 90 minute testing and tracked through QAPI/QA.(See attached checklist for annual testing)	3/4/22
K 541	Rubbish Chutes, Incinerators, and Laundry Chu	K 541		3/11/22

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	125014	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/16/2022**

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K 541 SS=D	Continued From page 2 CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: K-541 Rubbish Chutes, Incinerators, and Laundry Chutes This STANDARD is not met as evidenced by: Based on observation and staff interview with the maintenance director, the facility failed to ensure the proper operation of the self-closing fire rated door installed on the rubbish and laundry chutes. This observation of accumulated trash and laundry bags in the chute blocking the self-closing fire rated door is not in accordance with the 2012 edition of the NFPA 101 Life Safety Code, section	K 541	The accumulated trash and linen bags were cleared from the identified chutes immediately by the Environmental Services manager on 2/16/22. All residents, staff and visitors in in the health care center had the potential to be affected by the deficient practice. Measures and systemic changes that will be implemented to ensure this deficient	

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K 541	Continued From page 3 9.5.2. This deficient practice could affect all residents, staff, and visitors if smoke and fire was to extend vertically into the respective chutes. Findings include: An observation on 2/16/22 at approximately 12:15 pm revealed both laundry and trash chutes were overloaded and preventing the operation of the self-closing fire rated door. These findings were verified at the exit conference with the maintenance director and Administrator on 2/16/22 at 2:15 pm.	K 541	practice does not recur include the updated assignments for clearing chutes and tracking log to capture the time and frequency that the chute(s) were emptied, if indicated. In-service was completed by 3/11/22 to review new frequency of clearing chutes. (See in-service, Laundry and trash chute logs) The Facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur by random weekly audits to review trash and linen logs and visually check status of chutes by Environmental Services Manager or designee and report any significant findings through QAPI/QA. (See audit examples)	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K 918		4/15/22

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K 918	Continued From page 4 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: K-918 Electrical Systems-Essential Electric System Maintenance and Testing This STANDARD is not met as evidenced by: Based on record review and staff interview with staff members, the facility failed to produce documentation for inspection and testing of the alternate power source in accordance with NFPA 99 Healthcare Facilities Code, 2012 edition, section 6.6.4.1.1.2, and NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition, section 8.4.2.3. This deficiency could affect all residents, staff, and visitors during an interruption of grid power due to the lack of testing to ensure proper operation of the standby power system. Findings include: An observation on 2/16/22 at approximately 12:45 pm revealed that the facility failed to provide documentation for the generator load bank test. These findings were verified at the exit	K 918	The facility contacted certified/licensed contractor to schedule required load bank testing and setup visit at their earliest availability and to be completed by April 15, 2022. All residents, staff and visitors in the health care center had the potential to be affected by the deficient practice. Measures and systemic changes that will be implemented to ensure this deficient practice does not recur by having certified/licensed contractor adjust service agreement to perform annual load bank testing to ensure the Facility□'s generator can continue to operate during an interruption of grid power. The Facility will monitor its corrective	

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K 918	Continued From page 5 conference with the maintenance director and Administrator on 2/16/22 at 2:15 pm.	K 918	action to ensure that the deficient practice is being corrected and will not recur by reviewing annual reports for completion of the load bank testing and tracked through QAPI/QA.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full	K 923		3/11/22

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K 923	Continued From page 6 cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: K-923 Gas Equipment-Other This STANDARD is not met as evidenced by: Based on observation and staff interview with maintenance staff, the facility failed to provide adequate separation and proper signage and protect it from damage by means of a restraint for full and empty "E" oxygen cylinders and in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, sections 11.6.5.2, 11.6.5.3, and 11.6.2.3 (11). This deficiency could affect all residents requiring oxygen therapy by the possibility of administering an empty oxygen cylinder in lieu of a full cylinder during an emergency as well as injury to all occupants due to damaged unrestrained cylinders. Findings include: During facility survey on 2/16/22 at approximately 12:15 pm, revealed that the facility failed to provide adequate separation and proper signage, as well as proper cylinder restraint in the oxygen manifold room. These findings were verified at the exit conference with the facility manager and Administrator on 2/16/22 at 2:15 pm.	K 923	All oxygen storage rooms were audited on the ground, second and third floor - new tanks and empty tanks were identified, labeled and/or relocated on 2/16/22. The O2 tanks identified as not appropriately secured in the ground floor designated area was secured. New tags were placed on tanks as of 2/28/22. All residents in the health care center had the potential to be affected by the deficient practice. Measures and systemic changes that will be implemented to ensure this deficient practice does not recur include implementation of new labeling and storage carts to ensure adequate signage, separation and protection from damage is practiced. (see attached picture of racks tags) In-services for Maintenance and Nursing staff were completed by 3/11/22 on labeling, proper storage and securing Oxygen tanks. (see attached tags and in-services) The Facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur by	

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K 923	Continued From page 7	K 923	implementing weekly audits, which will be conducted by Environmental Services manager or designee through Worxhub tracking system. (See attached audit example). The findings will be reviewed by the Environmental Services Manager and tracked through QA.	

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

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

Electronically Signed | 03/14/2022

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.