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	125019	A. BUILDING _____ B. WING _____	02/25/2022

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THE CARE CENTER OF HONOLULU	1900 BACHELOT STREET HONOLULU, HI 96817

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 02/25/22. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. Survey Census: 147 Survey Dates: 02/22/22 to 02/25/22.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		4/1/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/21/2022

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F 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to exercise reasonable care for the protection of Resident (R) 152's property from loss or theft. As a result of this deficient practice, R152 was not able to use her personal belongings to the extent possible. Findings include: On 02/22/22 at 10:04 AM, R152 was observed sitting up in bed in her room and was alert to person, place, and time (answered questions appropriately). At 01:25 PM, an interview was conducted with R152 in the resident's assigned room. R152 stated, "My purple and black suitcase is missing. It has been missing since I moved out of my room because of COVID. I moved from the second floor to this floor. It (suitcase) was between the closet and window, and I haven't seen it since. I told the nurses that it was missing. No one was able to find it yet." Conducted a record review of R152's Electronic	F 584	R152s suitcase was replaced, and the Social Services Director confirmed on 3/21/22 to ensure that resident was happy with the replacement. Interviews/Audits will be done with residents currently residing in the facility to confirm there are no other residents identified to have missing items due to a recent room change. A grievance will be initiated for anyone affected. DON/Designee educated staff on 3/3/22, and on an ongoing basis, regarding using the room change checklist and resident's inventory list when moving resident's belongings. Administrator/Designee re-educated Department Heads, Social Services Staff, and Ward Clerks on 3/21/22, regarding the importance of printing the resident's inventory list when moving residents to a new room to verify their items are moved with them and to	

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F 584	Continued From page 2 Medical Record (EMR) on 02/23/22 at 05:30 PM. The resident was admitted to the facility on 05/22/21 for diagnosis of congestive heart failure. Review of R152's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/08/21, documented R152's Brief Interview for Mental Status (BIMS) score was 15, indicating the resident is cognitively intact. Section G. Functional Status documented R152 requires two-person assist for bed mobility, dressing, bathing, and toilet use indicating the resident is unable to move her belongings independently between rooms. The Census List form documented R152 was transferred between different rooms on the second floor five (5) times between 05/07/21 and 01/18/22 (approximately 8-month period) and on 01/21/22 moved from the second floor to the first floor. Review of the facility's Inventory of Belongings form dated 09/10/21, documented that R152 had "1 Luggage" in her possession while on the second floor. On 02/24/22 at 11:15 AM, inquired with Social Worker (SW)1 regarding R152's missing suitcase and SW1 stated that she would check if a report was made. At 1:11 PM, SW reported back to this surveyor and stated no prior knowledge of the incident and no report or grievance was made regarding R152's missing luggage. SW1 confirmed with R152 that the resident's clothing was in her suitcase when transferred from the second to the first floor, the resident was not missing any clothes indicating the luggage was transferred from the second to the first floor. However, R152's luggage is currently unaccounted for. On 02/25/22 at 07:42 AM, conducted an interview	F 584	identify any missing items timely. Social Services Director (SSD)/Designee will audit 5 room moves per week x 4 weeks to validate that inventory sheets were checked, and resident's items were moved as they occur. In addition, asking residents if they are missing items has been included in the Facility's Leadership Rounds Tool to verify ongoing compliance. SSD will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 584	Continued From page 3 and review of R152's Inventory of Belongings form (dated 09/10/21) and Room Change Checklist form (completed when R152 moved from the second floor to the first floor) with the Administrator (in the conference room). The Administrator confirmed that although there is an area on the Inventory of Belonging form for special items (dentures and hearing aids), staff do not check the list to ensure all the resident's belongings are accounted for when residents change rooms and a new inventory list only completed if belongings are added or removed from the list. The Administrator confirmed the facility's current practice of tracking resident's belonging during room changes does not account for or ensure all the resident's belonging are transferred with the resident.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		4/1/22

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F 656	Continued From page 4 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to develop a comprehensive person center care plan (CCP) that includes measurable objectives and timeframes to meet one resident (Resident (R)114) sampled. Due to a significant weight loss and an increase with difficulty swallowing, R114 had a gastronomy tube (GT) inserted, and a CCP for nursing care and interventions was not developed. An enteral formula was observed hanging beyond 24 hours rendering it expired and no documentation of staff monitoring for Refeeding Syndrome (Refeeding is the process of reintroducing food after malnourishment or starvation. Refeeding syndrome is a serious and	F 656	R114 care plan has been updated and is receiving care as ordered. Residents on tube feeding have the potential to be affected and will be audited to verify that MD orders are in place and care planned. DON/Designee re-educated nursing staff starting 3/10/22, and on an ongoing basis, regarding the care plan process and implementation of residents' plan of care. MDS Lead re-educated Licensed Nurses on step-by-step process of creating and updating care plans in Point Click Care	

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F 656	Continued From page 5 potentially fatal condition that can occur during refeeding. It's caused by sudden shifts in the electrolytes that help your body metabolize food). As a result of this deficiency, R114 is at risk of harm for unmet needs and care related to the newly inserted GT. Findings include: (Cross Reference to F693- Tube Feeding Management/Restore Eating Skills) R114 was admitted to the facility on 10/08/21 with diagnosis that include cerebrovascular disease, Dementia without behavioral disturbances, Alzheimer's disease, and a history of stroke. On 02/14/22, R114 returned to the facility following a gastrostomy tube (GT) placement for malnutrition. On 02/22/22 at 09:44 AM, observed a bag of Fibersource HN (enteral formula) hanging for R114 and labeled 30 ML (milliliters)/ (per) hour x 8 hours- Nocturnal (10 PM-6 AM), flush 30 ML water before and after 8 hours. The Fibersource HN formula and tubing (administration set) was dated 2/19/22 at 22:00 (10:00 PM), indicating the date and time the enteral formula started and tubing first used. On 02/23/22 at 09:05 AM, conducted a record review of R114's Electronic Medical Record (EMR). On 02/18/22 at 15:00 (3:00 PM), an active physician's order was started on Fibersource HN 50 ML (milliliters) per hour for 8 hours, monitor for Refeeding Syndrome and a physician's order for the placement of the g-tube related to R114's Dysphagia revised on 2/7/22. Review of the R114's CP documented the CP	F 656	starting 3/15/22, and on an ongoing basis. Night Shift Nursing Supervisor will audit residents with orders of tube feeding to verify that TF supplies are dated appropriately. DON/Designee will conduct random audits to include residents on each unit weekly x 12 weeks to validate that care plans are accurate, and residents are receiving nursing services according to the MD order and plan of care. In addition, checking that TF supplies are dated appropriately is added to the Facility's Leadership Rounds Tool to verify ongoing compliance. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 656	Continued From page 6 was not updated to include nursing care goals and interventions related to the g-tube or monitoring for Refeeding Syndrome. On 02/25/22 at 09:30 AM, shared observations and conducted interviews with Registered Nurse (RN)10 and RN11 independently. RN10 and RN11 confirmed the administration set is good for 24 hours and the administration set for R114 (dated 02/19/22 at 22:00) should have been replaced on 02/20/22 at 22:00 but was not changed. R114 received RN10 and RN11 both confirmed after 24 hours the administration set has the potential for bacteria contamination and increases the potential for infection and related complications. On 02/25/22 at 09:55 AM, shared observations and conducted an interview with the Administrator and the Director of Nursing (DON). The Administrator and the DON confirmed the administration set for enteral formula should be replaced after 24 hours. Conducted a review of the facility policy and procedure on 02/25/22 at 2:00 PM that listed under infection control to change the administration set every 24 hours and label it with the date and time.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		4/1/22

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F 657	Continued From page 7 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to revise one resident's (R)110 care plan (CP) to address his refusals to reposition in bed to treat his stage four pressure ulcer (PU) on his tailbone area, which was a deep wound extending down to his bone. This deficient practice failed to individualize R110's CP to explore the source of R110's refusals to reposition and has the potential to affect all residents who refuse nursing care. Finding includes: On 02/22/22 at 08:58 AM, an initial observation of R110 was made. R110 had a touch sensitive call light to the left of his head. He was able to answer	F 657	R110 skin care plan has been updated to include his refusals to turn. Residents refusing nursing care have the potential to be affected and an audit will be done to verify that their care plans are current and updated. Revisions made as indicated. DON/Designee re-educated Licensed Nurses starting 3/10/22, and on an ongoing basis, regarding the importance of care plans and its revision process. In addition, residents who refuse care will be discussed at Morning Clinical Meeting and interventions will be created as needed.	

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F 657	Continued From page 8	F 657	DON/Designee will conduct random audits to include residents on each unit weekly x 12 weeks to verify that revisions have been completed to address refusal of care and alternatives are available as needed. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

simple yes or no questions and said "no" when asked if he had any complaints. He had a tracheostomy (surgically created hole in his neck for breathing) connected to a ventilator (medical equipment to assist with breathing). He laid at a 45 degree angle in bed with a specialty mattress and watched his television.

On 02/22/22 at 1:29 PM, the facility's "MDS Resident Matrix" printed on 02/22/22 was reviewed. R110 was identified as having a stage four facility acquired PU.

On 02/23/22 at 10:14 AM, R110's dressing change to his PU on his tailbone was observed. The physician's assistant (PA) wound care specialist needed to remove dead tissue from R110's wound to promote tissue healing.

On 02/23/22 at 1:24 PM, R110 was observed to be sleeping on his back at a 45 degree angle. On 02/24/22 at 06:56 AM, R110 was observed to be sleeping in a 45 degree angle on his back with his television on.

On 02/24/22 at 07:13 AM, RN6 was queried at the nursing station if R110 was turned every two hours and she stated that he sometimes refused to turn because he liked to watch his television.

On 02/24/22 at 08:39 AM, a record review of R110's electronic health record (EHR) was done. R110's task flowsheet, "Turn and reposition approximately every two hours, as resident allows; attempt to keep off coccyx [tailbone] to help heal wound" revealed that he refused to turn 12 of the 18 days queried.

The "Wound Care SNF [skilled nursing facility]

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F 657	Continued From page 9	F 657		

Consult Service Progress Note" with encounter date 02/23/22 written by the PA wound care specialist, was reviewed. The following was documented: "41 year old male PMH [past medical history] Traumatic SCI [spinal cord injury] and Quadriplegia [paralysis of four limbs] ...Sacral [tailbone] wound is larger ...with continued bone exposure and increased depth to sacrum [tailbone] ...Pt [patient] is very difficult to offload [remove pressure from tailbone] secondary to respiratory status, contributing to the wound not healing ..."

R110's care plan, with last review done on 11/30/21, was read. The focus for "The resident has a pressure ulcer ...r/t [related to] immobility" did not have any interventions addressing his refusals to turn. There was no individual entry on R110's care plan to address and explore his refusals of care.

On 02/24/22 at 1:22 PM, licensed practical nurse (LPN)5 was interviewed in the hallway of the nursing unit. LPN5 stated that R110 refused to reposition sometimes due to complaints of neck pain when he needs to turn his neck to watch his television.

On 02/25/22 at 08:19 AM, R110 was interviewed in his room. He stated "yes" when asked if the staff turned him routinely. He was unable to answer when asked how often he was repositioned.

On 02/25/22 at 08:25 AM, ADON1 was interviewed at the nursing station. ADON1 agreed that R110's refusals to be repositioned should be care planned.

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F 657	Continued From page 10 On 02/25/22 at 1:30 PM, the facility's "Care Plans, Comprehensive Person-Centered" policy and procedure effective date 06/16/21, was reviewed. It stated: " ...10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are at the endpoint of an interdisciplinary process..."	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews (RR), the facility failed to ensure that R55's pressure injury (area of injured skin caused by constant pressure) was assessed, documented, and care planned by the nursing staff. This deficient practice could potentially have a serious outcome with R55 developing an unhealing wound and could potentially affect all residents who are unable to communicate and are at risk for pressure injuries.	F 686	R55 wound was evaluated, skin care plan has been updated, and resident's wound is healing. Residents with skin integrity issues have the potential to be affected. Audit of skin assessments will be done to verify documentation and care plans are in place. Revisions made as indicated. DON/Designee re-educated Licensed	4/1/22

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F 686	Continued From page 11 Finding includes: On 02/22/22 at 09:24 AM, an initial observation of R55 was made. R55 laid in bed on his back. He did not respond to any verbal stimulation. An electronic pump to deliver liquid nutrition was next to his bed. R55 was receiving oxygen through tubing delivered to his tracheostomy. Both of R55's elbows were bent, and his arms were stiff, close to his chest. He clenched in each of his hands a dark, green carrot-shaped apparatus. On 02/22/22 at 12:15 PM, R55's family member (FM) was interviewed at his bedside. FM was massaging and exercising R55's limbs and revealed a tan, square bandage covering R55's right heel. FM stated that R55 had a wound on his heel. On 02/22/22 at 8:32 PM, R55's care plan was reviewed. There was no indication on the presence of a wound on R55's right heel and its associated treatment. On 02/23/22 at 1:47 PM, an RR of R55's EHR was done. R55 is a 65 year old admitted to the facility for chronic respiratory failure. R55's quarterly "Minimum Data Set" (MDS) with assessment reference date (ARD) of 12/29/21 revealed under "Section B Hearing, Speech, and Vision" that he does not speak and is not understood or is able to understand others. "Section M Skin Conditions" revealed that he is at risk for developing pressure injuries. A continued RR of R55's physician's orders revealed an order with a start date of 01/17/22: "Cleanse with Ns [normal saline (solution)], apply skin prep, and foam dressing to right heel every	F 686	Nurses starting 3/10/22, and on an ongoing basis, regarding the importance of completion of skin assessments, documentation of assessment, and care planning. Licensed Nurses are to report and document changes in skin condition to shift supervisor, develop care plan, and follow up on needed treatment(s). Then Supervisor will verify that care plan is in place with IDT team at Morning Clinical Meeting. DON/Designee will conduct random audits to include residents on each unit weekly x 12 weeks to verify that skin assessments have been completed timely, treatments are done as ordered, and care plan is in place. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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	125019	A. BUILDING _____ B. WING _____	02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 12 night shift every Mon [Monday], Thu [Thursday] for for (sic) frail skin until healed." Progress notes documented from 01/17/22 to 02/24/22 were reviewed. There was no documentation describing R55's right heel found. "Skin Observation Tool" documents for 01/25/22, 01/28/22, 02/01/22, 02/11/22, 02/15/22, and 02/18/22 were reviewed. There were no skin assessments of R55's right heel. On 02/25/22 at 08:33 AM, a concurrent observation and interview were done with RN8 and ADON1 at R55's bedside. The tan, square bandage was removed from R55's right heel and revealed a demarcated, round and light-red, nickel-sized area. The skin was intact and there was no drainage noted. RN8 stated that skin assessments are done twice a week and if the certified nurse's aide (CNA) reported any irregularities. The skin assessment is documented either on the "Skin Observation Tool" or in a progress note. ADON1 stated that the skin condition of R55's right heel, which currently has a pressure injury, should have been assessed, documented and care planned by a nurse. On 02/25/22 at 1:40 PM, the facility's "Pressure Injuries/Skin Breakdown Policy & Procedure" was reviewed. Under "Assessment and Recognition" it stated, " ...2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure injury including location, stage, length, width and depth, presence of exudates [drainage] or necrotic [dead] tissue ..."	F 686		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition	F 693		4/1/22

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F 693	Continued From page 13 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure a resident who receives enteral formula receives the appropriate services to prevent complications. Resident (R)114 received enteral formula and tubing used beyond 24 hours increasing the potential for bacteria contamination of the administration set (formula and tubing); the enteral formula hanging was labeled to infuse at 30 milliliters (ml) per hour but the physician's order documented a rate of 50 ml per hour; and no comprehensive person centered care plan was developed related to nursing care, intervention management, or monitoring for Refeeding Syndrome (Refeeding is the process of reintroducing food after malnourishment or	F 693	R114 TF supplies were discarded and replaced, care plan was updated and is receiving care as ordered. Residents on tube feeding have the potential to be affected and will be audited to verify that MD orders are in place, care planned, and dated appropriately. Revisions made as indicated. DON/Designee re-educated nursing staff starting 3/10/22, and on an ongoing basis, regarding the care plan process and implementation of residents' plan of care and the importance of appropriately changing the tubing set to avoid	

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F 693	Continued From page 14 starvation. Refeeding syndrome is a serious and potentially fatal condition that can occur during refeeding. It's caused by sudden shifts in the electrolytes that help your body metabolize food). As a result of this deficiency, the resident is at risk for potential harm. Findings include: (Cross Reference to F656- Development of a Comprehensive Care Plan) R114 was admitted to the facility on 10/08/21 with diagnosis that include cerebrovascular disease, Dementia without behavioral disturbances, Alzheimer's disease, and a history of stroke. On 02/14/22, R114 returned to the facility following a gastrostomy tube (GT) placement for malnutrition. On 02/22/22 at 09:44 AM, observed a bag (with approximately 350 mls (milliliters) left) of Fibersource HN (enteral formula) hanging for R114 and labeled 30 ML/ (per) hour x 8 hours-Nocturnal (10 PM-6 AM), flush 30 ML water before and after 8 hours. The Fibersource HN formula and tubing (administration set) was dated 2/19/22 at 22:00 (10:00 PM), indicating the date and time the enteral formula started and tubing first used. On 02/23/22 at 09:05 AM, conducted a record review of R114's Electronic Medical Record (EMR). On 02/18/22 at 15:00 (3:00 PM), an active physician's order was started on Fibersource HN 50 ML per hour for 8 hours, monitor for Refeeding Syndrome. However, this surveyor observed a discrepancy between the physician's ordered infusion rate of 50 ml per	F 693	contamination. MDS Lead re-educated Licensed Nurses on step-by-step process of creating and updating care plans in Point Click Care starting 3/15/22, and on an ongoing basis. In addition, Night Shift Nursing Supervisor will audit residents with orders of tube feeding to verify that TF supplies were changed and dated appropriately. DON/Designee will conduct random audits to include residents on each unit weekly x 12 weeks to validate those residents are receiving nursing services according to the MD order, their plan of care, and supplies are dated and used appropriately. In addition, checking that TF supplies are dated appropriately is added to the Facility's Leadership Rounds Tool to verify ongoing compliance. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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F 693	Continued From page 15	F 693		

hour and the observation (made on 02/22/22 at 09:44 AM) of the label on the enteral formula hanging documented the rate of infusion as 30 ml per hour with approximately 350 mls left. A physician's order for the placement of the GT related to R114's Dysphagia (revised on 2/7/22) and a progress note on 02/14/22 at 2:29 PM documented R114 returned to the facility on 2/14/22 following the insertion of the GT. Review of the R114's CP documented the CP was not updated to include nursing care goals and interventions related to the GT and monitoring for Refeeding Syndrome upon returning to the facility.

On 02/25/22 at 09:30 AM, shared observations and conducted interviews with Registered Nurse (RN)10 and RN11 independently. RN10 and RN11 confirmed the administration set is good for 24 hours and the administration set for R114 (dated 02/19/22 at 22:00) should have been replaced on 02/20/22 at 22:00 but was not changed. R114 received RN10 and RN11 both confirmed after 24 hours the administration set has the potential for bacteria contamination and increases the potential for infection and related complications.

On 02/25/22 at 09:55 AM, shared observations and conducted an interview with the Administrator and the Director of Nursing (DON). The Administrator and the DON confirmed the administration set for enteral formula should be replaced after 24 hours.

Conducted a review of the facility policy and procedure on 02/25/22 at 2:00 PM that listed under infection control to change the administration set every 24 hours and label it with

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F 693	Continued From page 16 the date and time.	F 693		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the	F 755	R405 MD order was changed, and a	4/1/22

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F 755	Continued From page 17 facility failed to provide proper pharmaceutical services as evidenced by Resident (R)405 receiving a medication the resident was allergic to due to the facility not verifying the resident's allergies upon admission. As a result of this deficient practice, R405 was administered a medication that she has a history of being allergic to and was put at potential risk for adverse side effects. Findings include: Conducted a record review of R405's Electronic Medical Record (EMR) in the conference room on 02/24/22 at 9:00 AM. The EMR documented R405 was admitted on 02/16/22 from the hospital for acute hypoxic (not enough oxygen in the blood) and hypercapnic respiratory failure (high levels of carbon dioxide in the blood). Other diagnoses include dysphagia (difficulty swallowing) and myasthenia gravis (a neuromuscular disorder that leads to weakness of skeletal muscles). A skilled progress note dated 02/17/22, stated, "Resident desats (desaturated) 3x (three times) this shift down to 85%. Positive wheezing, suctioned thick whitish secretions ...MD (medical doctor) Gries was notified with new order to start on Zosyn 2.25 g every 8 hours for 2 weeks x (for) PNA (pneumonia). Initiated this shift ...No ASE (adverse side effects) noted, no fever." In a general progress note dated 02/22/22 at 05:10 PM, Registered Nurse (RN)1 documented, "Noted tremors and lower extremities occasionally. Denies pain when asked. Currently on Zosyn IV (intravenous) for PNA (Pneumonia) given at 1400 (02:00 PM), no adverse reaction noted at this time ...Reviewed medication to Dr. Gries from AVS (After-Visit Summary) from QMC	F 755	review of all orders (current and discontinued) show no other medications since admission have an allergy warning. Residents residing in the facility with medication allergies have the potential to be affected. Audit of medication orders will be done, and any potential cross allergies will be reviewed with the MD. SDC/Designee re-educated Licensed Nurses on 3/10/22, and on an ongoing basis, regarding reconciliation process for new admissions. Night Supervisors will conduct an audit for reconciliation of new admit orders versus allergies and turn in to DON/Designee to be reviewed/confirmed at Morning Clinical Meeting. DON/ Designee will audit all new admissions x 12 weeks to verify that medication reconciliation was done, and any discrepancies were identified and resolved timely. DON/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed. In addition, Medication Reconciliation will be included into the QAPI Agenda for ongoing review.	

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F 755	Continued From page 18	F 755		

(Queen's Medical Center) ...noted resident allergic to Zosyn per record, referred to Dr. Gries and ordered to D/C (discharge) Zosyn and start on Clindamycin 600 mg IV (intravenous) Q (every) 8 hours x (for) 8 days for PNA (pneumonia)." The After Visit Summary dated 02/16/22 documented, "Allergies: Zosyn [piperacillin-tazobactam]. Rash, Swelling". Review of R405's Medication Administration Record (MAR) documented the resident was administered 15 doses of Zosyn 2.25 gm (gram) from 02/01/22 to 02/28/22.

On 02/24/22 at 09:49 AM, RN1 was interviewed near the nursing station on the first floor. RN1 stated, "I came back to work from vacation and noticed that R405 was having tremors, so I reviewed her After-Visit Summary from Queen's Medical Center. That's when I noticed that she was allergic to Zosyn. I called Dr. Gries and explained what happened so that we can change the order. When we have an admission, the nurse reviews the resident's After-Visit Summary and discharge record for any changes in the patient's medication or orders and verifies it with the doctor. I did not admit this resident."

On 02/24/22 at 10:07 AM, Assistant Director of Nursing (ADON)1 was interviewed at the front desk on the first floor. ADON1 confirmed R405's medications were not reconciled upon admission, received a medication the resident had a documented allergy to, and stated, "When someone is admitted, we reconcile all of their medications. That should have been done when she (R405) came in. The supervisor of the evening shift should be making sure that the medication reconciliation was done. The medication that R405 was allergic to was missed.

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F 755	Continued From page 19 R405 does have MS (myasthenia gravis) which we thought was causing her tremors and got her medication, but the tremors must have prompted RN1 to review her medications again." On 02/25/22 at 01:00 PM, reviewed the facility's policy and procedure, "Reconciliation of Medications on Admission/Re-admission" approved 06/14/21. The policy stated, "D. Steps in the Admission/Re-Admission Procedure. 1. If a medication history has not been obtained from the resident or legal representative, complete this first. Information from the medication history should include: ...Diagnoses and allergies should also be reconciled at each transition."	F 755		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		4/1/22

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F 812	Continued From page 20 by: Based on observation and interview with staff member the facility failed to ensure all foods shall be stored under sanitary conditions as evidenced by a scooper stored in a container of thickener. Findings include: On 02/22/22 at 08:15 AM, during the initial kitchen tour with Director of Dietary Services (DD), in the dry goods storage room, observed a large plastic container filled with thickener and a scooper stored inside the container touching the thickener. DD stated the scooper is stored in the container on a rack to not touch the thickener but the container was overfilled. DD confirmed the scooper is not supposed to be touching the thickener and should be filled to a level that the scooper does not touch the product.	F 812	Director of Dietary Services (DDS) removed the scooper storage from the container, and from all related type/use containers to ensure best and safest practices for all related food storage. Residents receiving food/drinks containing thickener and/or ingredients stored in bulk, have the potential to be affected. The process of obtaining bulk ingredients from dry storage, using scoopers, was updated to single use only. All scoops are to be cleaned between uses to remove the chance of bulk food/ingredient contamination via scoop handle contact. DDS/Designee educated dietary staff starting 3/6/22, and ongoing basis, regarding the new process to ensure foods are stored under sanitary conditions. DDS/Designee will audit dry goods storage room 5 times per week x 12 weeks to validate compliance with new process and scoopers are not stored in the storage room. DDS will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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E 000	Initial Comments A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on 02/25/22. The facility was found to be in substantial compliance with Appendix Z, Emergency Preparedness, §42 CFR 483.73 for long term care facilities.	E 000		

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

Electronically Signed | 03/21/2022

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.

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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 02/22/22. The Facility was found not to be in compliance with the requirements of 42 CFR 483.90. The Care Center of Honolulu is a two-story skilled nursing facility. The facility was constructed in 1960 of concrete flooring, roofing and bearing walls. The facility has temporary generator that supplies back up power to the entire building.	K 000		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and interview with facility staff, the facility failed to ensure that exit signs were continuously illuminated in accordance with NFPA 101 (2012 edition) sections 7.10.4 and 7.9.2.7. This had the potential to delay exit from the facility in the event of an emergency which could affect all 147 residents. Findings include: Observation on 02/22/22 from 12:40 PM to 12:45 PM on the second floor revealed exit and	K 293	Facility-wide audit of exit signs was conducted on 2/25/22 and all exit signs identified were replaced with illuminating signs that are tied into the generator with built-in battery backup. Residents residing in the facility have the potential to be affected. Administrator/Designee educated maintenance staff regarding the requirements of exit signages including	3/4/22

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	125019	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/22/2022**

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THE CARE CENTER OF HONOLULU	**1900 BACHELOT STREET** **HONOLULU, HI 96817**

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K 293	Continued From page 1 directional signs not continuously illuminated including; an exit directional sign in the Physical Therapy area, one exit sign in the Physical Therapy area, one directional exit directional sign near bedroom 200 in the main exit access corridor, one exit sign in the corridor near bedroom 226, one exit sign near bedroom 227 on the other side of the smoke barrier wall in the main corridor, one exit sign at bedroom 237 in the corridor, one exit sign in the corridor near bedroom 205, and one exit sign near bedroom 219 in the corridor. Observation on the first floor on 02/22/22 from 12:50 PM to 12:55 PM revealed exit and directional exit signs not continuously illuminated including; one exit sign in the main dining room, one exit sign near bedroom 115 in the main corridor, one exit sign near bedroom 102 in the main corridor, one exit sign near bedroom 118 in the corridor, one exit sign near bedroom 126 in the corridor and one exit sign near bedroom 135 in the corridor. In addition, two exit signs connected to the house electric and emergency system were noted in the laundry area in the lower level of the building. Both exit signs were not illuminated and did not work. Interview with the Maintenance Director on 02/22/22 at 1:00 PM verified the exit signs were not continuously illuminated and were not wired into the emergency lighting system or generator. The Maintenance Director confirmed the two exit signs in the laundry were not working. During an interview with on 02/22/22 at 3:00 PM, the Administrator stated the expectation is for the signs to be visible at all times and especially under emergency conditions.	K 293	the testing of exit signs. The Facilities Manager/Designee will audit exit signs weekly x 8 weeks to verify that they are illuminated. Monthly checks of exit signs added to the work order system for documentation to validate ongoing compliance by testing every month for 30 seconds and annually for 90 minutes. The Facilities Manager/designee will present findings at the QAPI meeting until QAPI committee validates compliance is sustained.	

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K 293	Continued From page 2 The code requires under NFPA 101 (2012 edition) section 7.10.4 that " ...where emergency lighting is required by applicable sources, (see NFPA 101 2012 edition section 7.9.2.7) the signs shall be illuminated by the emergency lighting facilities." The code requires under NFPA 101 (2012 edition) section 7.9.2.7 that " ...the emergency lighting system shall be either continuously in operation or capable of repeated automatic operation without manual intervention."	K 293		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames	K 363		4/15/22

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K 363	Continued From page 3 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure that smoke barrier doors or corridor bedrooms doors resisted the passage of smoke and latched closed into the frame in accordance with NFPA 101 (2012 edition) section 19.3.6.3.1 and 19.3.6.3.5. This failure had the potential to affect 103 residents in four of six smoke zones. Findings include: Observation of the second-floor corridor bedroom door 216 on 02/22/22 at 9:40 AM revealed the door when closed two times, did not latch into the frame. Interview with the Maintenance Director at the time of the observation verified the door would not close and latch into the frame. Observation of the second-floor corridor bedroom door 209 on 02/22/22 at 9:50 AM revealed paper inside the door frame stuffed into the opening prevented the door from latching. Interview with the Maintenance Director at the time of the observation verified the door would not close and latch into the frame. Observation of the second-floor corridor bedroom door 217 on 02/22/22 at 10:00 AM revealed the	K 363	Corridor doors 216, 209, 217, 230, 235, 129, 131 and the kitchen door were repaired. Facility-wide audit was conducted by Maintenance Staff on 3/4/22 to validate that doors are capable of closing, that there are no impediments to closing doors and doors are up to NFPA standards. A third-party vendor is scheduled to further assess doors identified from facility-wide audit and fix them as needed. Residents residing in the facility have the potential to be affected. Staff were re-educated starting 3/3/22, and on an ongoing basis, regarding the requirement that smoke barrier doors and corridor bedroom doors resist the passage of smoke and latches closed into the frame. The Facilities Manager/Designee will conduct a random audit of rooms on each	

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K 363	Continued From page 4 door when closed two times, did not latch into the frame. Interview with the Maintenance Director at the time of the observation, verified the door would not close and latch into the frame. Observation of the second-floor corridor bedroom door 230 on 02/22/22 at 10:20 AM revealed the door, when closed two times, did not latch into the frame. Interview with the Maintenance Director at the time of the observation verified the door would not close and latch into the frame. Observation of the second-floor corridor bedroom door 235 on 02/22/22 at 10:25 AM revealed the door, when closed two times, did not latch into the frame. Interview with the Maintenance Director at the time of the observation verified the door would not close and latch into the frame. Observation of first-floor corridor bedroom door 129 on 02/22/22 at 11:00 AM revealed the door, when closed two times, did not latch into the frame. Interview with the Maintenance Director at the time of the observation verified the door would not close and latch into the frame. Observation of the first-floor corridor bedroom door 131 on 02/22/22 at 11:01 AM revealed the door, when closed two times, did not latch into the frame. Interview with the Maintenance Director at the time of the observation verified the door would not close and latch into the frame. Observation of the first-floor kitchen door located off the main dining room on 02/22/22 at 11:50 AM revealed the door stuck in the open position completely thus allowing for elements of fire and smoke to enter the dining from the kitchen. The door was stuck open on the floor. Interview with the Maintenance Director at the time of the observation verified the kitchen door was stuck open on the floor. Interview with the Maintenance Director on 02/22/22 at 12:00 PM indicated the facility	K 363	unit weekly x 8 weeks to validate that corridor doors close and latch into the frame. The Facilities Manager/designee will present findings at the QAPI meeting until QAPI committee validates compliance is sustained.	

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K 363	Continued From page 5 completes quarterly checks of corridor doors but produced no documentation of such checks. During an Interview on 02/22/22 at 3:00 PM the Administrator indicated the expectations were all corridor door close and latch into the frame. The code under NFPA 101 (2012 edition) sections 19.3.6.3 requires doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be constructed to resist the passage of smoke and fire for 20 minutes" The code Under 19.3.6.3.5. requires "doors shall be provided with a means of keeping the door closed that is acceptable to the authority having jurisdiction and the following shall apply to the device. The device shall be capable of keeping the door fully closed if a force of five pounds or more of pressure is applied."	K 363		
K 915 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours.	K 915		6/30/22

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K 915	Continued From page 6 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that it provided a Type I essential electrical system (EES) in accordance with NFPA 99 (2012 edition) sections 6.3.2.2.10.1, 6.4.2.2.1.1, 6.4.2.2.1.2, 6.4.2.2.1.3 and 6.4.2.2.1.4. Lack of the proper essential electrical system could result in power failure in one part of the building, affecting power to the resident bedroom outlets. This had the potential to affect the 17 residents on life support who reside in the facility. Findings include: Observation of the facility generating room or electrical room on the lower level of the facility on 02/22/22 at 11:50 AM revealed the facility has one transfer switch for the entire facility establishing a Type II or Type III EES, not a Type I EES. The facility is using a temporary generator until its new generator arrives from the mainland schedule for June 2022. Interview with the Administrator on 02/22/22 at 3:00 PM revealed the facility has 17 patients on life support. The patients on life support reside primarily on the Hale One unit. The Administrator confirmed the facility has only on transfer switch. The code requires the following of a Type I EES: The code under NFPA 99 (2012 edition) section 6.3.2.2.10.1 requires " ...critical rooms (category 1 room) shall be served by a type I EES." Critical care is characterized as an "electrical system failure is likely to cause major injury or death of patients." The code under NFPA 99 (2012 edition) section 6.4.2.2.1.1 requires " ...the EES shall be divided into the following three branches: 1) Life Safety,	K 915	The Facility continues to use a temporary generator until the newly purchased generator arrives from the mainland as scheduled. The new generator will include the installation of the three new transfer switches, along with an alarm annunciator. The Facility has been working with Coffman Engineers to modernize the backup power system for the entire building. This is typically a lengthy process which includes design, City & County design approval, permitting, rewiring of the electrical switchgear, arrival of generator from the mainland, followed by installation, construction, and energization. The initial timeline estimated for completion of the new backup power system by June 2022. Maintenance staff will be educated on conducting monthly testing and weekly inspections when the new generator is installed. Residents on ventilators have the potential to be affected. Maintenance staff have been re-educated on requirements for and maintenance of transfer switches and ongoing generator maintenance. Maintenance staff were also educated after the installation of the portable generator to ensure the proper backup power system is continuously operational.	

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K 915	Continued From page 7 2) Critical, 3) Equipment. The code under NFPA 99 (2012 edition) section 6.4.2.2.1.2 requires " ...the division between the branches shall occur at transfer switches where more than one transfer is required." The code under NFPA 99 (2012 edition) section 6.4.2.2.1.3 requires " ...each branch shall be arranged for connection within time limits specified in this chapter" (10 seconds). The code under NFPA 99 (2012 edition) section 6.4.2.2.1.4 requires " ...the number of transfer switches to be used shall be based on reliability, design and load considerations. A) Each branch of the EES shall have one or more transfer switches. B) One transfer switch shall be permitted to serve one or more branches in a facility with a continuous load of 150 kVA [volt-ampere] or (120 kW [kilowatt]) or less	K 915	The Facilities Manager/Designee continues to test generator weekly and monthly to validate proper operation. The Facilities Manager/Designee will present findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview, the facility failed to ensure that a remote alarm annunciator was available in a location readily available to personnel at a regular	K 916	Past noncompliance: no plan of correction required.	3/27/22

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K 916	Continued From page 8 working station in accordance with NFPA 99 (2012 edition) section 6.4.1.1.16.2 and 6.4.1.1.17. This had the potential to affect all 147 current residents including the 17 residents who are on life support. Findings include: Observations on the facility tour on 02/22/22 from 9:40 AM to 12:00 PM revealed no evidence of a remote annunciator panel anywhere in the building. Interview with the Administrator on 02/22/22 at 3:15 PM and Maintenance Director revealed the facility does not have a remote annunciator for the generator anywhere in the certified building. Review of repair documents dated 01/22/21 revealed the facility had a 60-KW diesel powered generator and a Type II EPSS (emergency power supply system). The documents did not include reference to a remote annunciator panel. The facility had dismantled the original generator and were using a temporary generator until the new generator ordered from the mainland arrives as scheduled in June 2022. The facility did not install a remote annunciator panel with the temporary generator. The code requires under NFPA 99 (2012 edition) section 6.4.1.1.17 and 6.4.1.1.16.2 "A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room at a location readily observed by operating personnel at a regular work-station." Section 16.4.1.1.16.2 indicates the following warnings shall be present for the remote annunciator including " ...over crank, low water temperature, high engine temperature-pre alarm, high engine temperature, low lube oil pressure-pre-alarm, low lube oil pressure, overspeed, low fuel main tank, low coolant, EPS supplying load, control switch not in automatic position, high battery voltage, low	K 916		

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K 916	Continued From page 9 battery cranking voltage, low voltage in battery, battery charger A/C failure, lamp test, contacts for local or remote common alarm, audible alarm silencing switch, low starting air pressure, low starting hydraulic pressure, air shutdown damper when used, remote emergency stop."	K 916		
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on review of facility training records and interview with the Administrator, the facility failed to ensure that all personnel were trained in the safety and handling of medical gas and cylinders in accordance with NFPA 99 (2012 edition) sections 11.2.5.1. and 11.5.2.1.2 and 11.5.2.1.3. This failure had the potential to affect all 147 residents. Findings include: Review of the facility training documents on 02/22/22 at 1:00 PM revealed the facility lacked documentation of any type of training in the handling of medical gas and cylinders and the risks involved in such handling.	K 926	Administrator educated Facilities Manager, HR Manager, and Director of Staff Development on 2/22/22 on the importance of including training and documentation of such training for staff. Residents residing in the facility have the potential to be affected. Staff were educated starting 3/3/22, and on an ongoing basis, regarding the use and safe handling of oxygen cylinders. The HR Manager/Designee will audit employee files x 8 weeks to validate those personnel received education in handling and risks associated with oxygen and	4/15/22

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K 926	Continued From page 10 During an interview, with the Maintenance Director and Administrator, on 02/22/22 at 3:00 PM, the Maintenance Director stated he/she had not been trained on the use and safe handling of oxygen cylinders. The Administrator stated she checked with human resources and found no documents related to training for the handling and risks associated with oxygen and oxygen cylinders. The code requires under 11.5.2.1.2 that "personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education including safety guidelines and usage requirements." The code also requires under NFPA 99 (2012 edition) section 11.5.2.1.3 that "continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gas and their cylinders."	K 926	oxygen cylinders. Education on the use and safe handling of oxygen cylinders was also added to general orientation for appropriate new hires and on the annual training for personnel concerned with the application, maintenance and handling of medical gases and cylinders. The HR Manager/Designee will report findings to QAPI committee to evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed.	

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E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Hawaii, Department of Health on 02/22/22. The facility was found to be in compliance with 42 CFR 483.73.	E 000		

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

Electronically Signed | 03/27/2022

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.