STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. Four facility reported incidents (FRI) were investigated (ACTS #9458, 9315, 8961, 9250) There were no deficient practices cited related to the FRI investigations. Survey Dates: 05/10/22 to 05/13/22 Survey Census: 31 residents Sample Size: 14 residents	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and resident interviews, the facility failed to ensure the resident's right to an environment that promotes his or her quality of life as evidenced by staff speaking another language while providing care to a resident. Findings include: On 05/13/22 at 11:10 AM, this surveyor overheard two staff members speaking Filipino in the hallway directly outside the anonymous resident's doorway after providing care to the resident. At 11:16 AM, this surveyor entered the resident's room and inquired if staff speak another language while providing care to the resident. The resident requested to be anonymous and confirmed that staff have spoken to each other in Filipino while	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 providing care and directly outside the resident's room after providing care. The resident expressed that he/she felt staff were speaking negatively about the resident and caused the resident to feel self-conscious and badly about the resident's physical condition. The resident stated that it is embarrassing to have staff clean him/her up after defecating and he/she feels like staff could be "making fun of me of all I know, because I don't know what they are saying."	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure the resident's right to reasonable accommodations of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Findings include: On 05/11/22 at 12:40 PM, observed Resident (R)6 lying in bed. The bed was approximately size of a twin bed, there was less than 12 inches on either side of the resident to turn or move, and R6 took up the length of the bed. Inquired with R6 regarding the size of the resident's bed. The resident stated that the bed is too small for him. R6 moved from side to side to demonstrate that	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 3	F 558		

there is no room for the resident to roll to either side. R6 reported when staff need to provide peri care it is difficult for staff to maneuver him and feels like he will roll off the bed. The resident pointed to an empty bed, which was notably larger than the resident's current bed, and stated that he used to use that bed and is not sure why he was moved to a smaller bed.

On 05/13/22 at 08:10 AM, conducted an interview with the Director of Nursing (DON) regarding the size of R6's bed. The DON confirmed R6's bed is too small for the resident and the resident bed was changed because the larger bed's height could not be adjusted to the same height as R6's wheelchair for therapy reasons.

On 05/13/22 at 08:56 AM, conducted an interview with the Physical Therapist (PT)1 regarding R6's small bed and physical therapy goals. PT1 stated the resident was changed to a smaller bed due to a goal to return home and be able to transfer from the wheelchair to the bed (vice versa) via sliding board. PT1 stated R6 is not participating in physical therapy, is not currently unable to use the sliding board for transfers and is currently using a Hoyer lift for transfers. PT1 confirmed R6 does not currently need to be in the smaller bed and the resident should have been changed back to a bed that is more suitable for the resident's size.

On 05/13/22 at 11:56 AM, conducted a record review of R6's Electronic Medical Record (EMR). R6 weighed between 350.4 lbs. (pounds) and 340.8 lbs. from 02/19/22 to 05/05/22. Review of R6's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/24/22 documented in Section C- Cognitive Patterns, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 4 resident's Brief Interview for Mental Status (BIMS) score was 15 indicating the resident's cognition is intact.	F 558		
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 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	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 5	F 656		

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 observation, record review, and interview, the facility failed to develop a person-centered care plan for three (3) residents (Resident (R)3, R132, and R31), out of 14 residents sampled. A comprehensive care plan to address R3's risk for pressure ulcer was not developed. R132 did not have an appropriate, individualized care plan for his dementia. Bilateral heel protectors for R31's feet were not care planned appropriately to include time frames for use and interventions to check the skin on his feet where possible injury could occur. This deficient practice has the potential to affect all residents in the facility.

Findings include:

1) R3 was admitted to the facility on 10/22/21 with diagnosis that include hemiplegia and hemiparesis following a stroke, diabetes mellitus type 2 with other skin complications, heart failure, cognitive and communication deficits, and congestive heart failure. Review of R3's admission MDS with an Assessment Reference Date (ARD) of 10/28/2021 documented Section G- Functional Status, G0110. Activities of Daily Living (ADL) Assistance, the resident is totally dependent on staff for bed mobility (how the resident moves to and from lying position, turns

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 6	F 656		

side to side, and positions body while in bed or alternate sleep furniture) with two or more staff for physical assistance. R3 is totally dependent on staff to perform all ADLs (eating, dressing, toilet use, and personal hygiene). Review of Section V- Care Area Assessment (CAA) Summary, V0200- CAAs and Care Planning, A16 Pressure Ulcer care area was triggered and checked as addressed in care plan.

Multiple observations were made throughout the survey (05/10/22 at 10:51 AM, 12:10 PM, 1:35 PM, 2:15 PM; 05/11/22 at 10:32 AM, 11:50 AM, 12:57 PM, 2:45 PM; and 05/12/22 08:31 AM, 09:15 AM, 11:40 AM, 12:05 PM, 1:05 PM, 2:10 PM) of the resident lying in bed in a supine position (on the resident's back) with a wedge near the resident's left arm. The resident was not observed to be repositioned to the right or left and remained on his back. The wedge was not used to off load points of pressure or to reposition the resident. On 05/10/22 at 10:51 PM and 1:35 PM; 05/12/22 at 12:05 PM, 1:05 PM, 2:10 PM observed R3 had slipped down in the bed and the resident's foot was in direct contact with the bed's foot board.

On 05/13/22 at 09:55 AM, conducted a concurrent interview and record review of R3's Electronic Medical Record (EMR) with the Director of Nursing (DON). The DON navigated R3's EMR and confirmed that the risk of pressure ulcer(s) was identified in the Care Area Assessment on the resident's admission and a significant change MDS and marked as address in the resident's care plan. The DON reviewed R3's care plan and confirmed a care plan was not developed for pressure ulcers or for repositioning R3 and should have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 7	F 656		

2) Conducted a review of R132's EMR on 05/10/22 at 4:00 PM. R132 was admitted to the facility with diagnosis that include Dementia. Review of the resident's care plan revealed Dementia care and activities aligned with the resident's cognitive status were not included.

Observations were made of R132 on 05/10/22 at 10:15 AM and 1:10 PM; 05/11/22 at 09:45 am, 11:04 AM, and 1:15 PM during which the resident was not engaged in any activities with respect to the resident's cognitive ability. During an interview with R132, the resident was not alert and oriented to person, place, time, or situation. R132 was observed calling out for staff, crying, and yelling. On 05/12/22 at 09:30 AM, this surveyor observed a folded newspaper at the foot of the resident's bed. Due to R132's fractured femur, the resident was unable to reach the newspaper located at the foot of her bed.

During an interview and concurrent record review with the DON on 05/13/22 at 10:15 AM, the DON confirmed that a dementia care plan with appropriate activities was not developed for R132. A care plan included R132's dependence on staff for emotional, intellectual, physical, and social needs related to physical limitations with interventions to invite the resident to scheduled activities and to provide the resident with materials for individual activities such as newspaper, magazines, jigsaw puzzles, and crossword puzzles. The DON confirmed the activities were not appropriate for R132 due to the resident's diagnosis of Dementia and severe cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 8	F 656		

3) On 05/10/22 at 10:15 AM, an initial observation of R31 was made in his room. R31 laid in bed and responded softly to his name. R31 did not answer any of state agency's (SA) questions. Partially uncovered by his blanket, a blue padded device was noted to be on his right foot.

On 05/11/22 at 09:15 AM, R31's electronic medical record (EMR) was reviewed. R31 is a 70-year-old resident admitted to the facility on 03/17/22 with the diagnosis of respiratory failure and low blood oxygen related to a stroke caused by bleeding in the brain. R31's care plan, with care plan review completed on 04/05/22, did not indicate time frames for the use of the foot device and care interventions for skin assessments to his foot.

On 05/12/22 at 1:22 PM, Registered Nurse (RN)4 was interviewed at the nursing station. RN4 stated that R31 had "heel lifts" on both of his feet to protect his heels from pressure injury due to being in bed. He was unsure of where the devices originated from and suggested that maybe it came from the therapies department. RN4 confirmed stated R31's care plan did not include his use of heel protectors and the required care interventions. At 1:40 PM, a follow up query was made with physical therapist (PT)2 in the therapies department about R31's heel protectors and she stated that R31 was transferred to the facility with them.

On 05/13/22 at 07:45 AM, a concurrent interview and observation was done with the Director of Nursing (DON) at R31's bedside. The DON confirmed that R31 had heel protectors and a care plan is required to outline time frames and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 9 interventions for their use to ensure skin breakdown on R31's feet do not occur. On 05/13/22 at 3:30 PM, the facility's "Care Plans, Comprehensive Person-Centered" policy "Version 1.3 (H5MAPL0110)" was reviewed. It stated, " ...8. The comprehensive, person-centered care plan will: ...b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; ...	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 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	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 10	F 657		

team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to develop an individualized care plan for one resident, R31, out of a sample of 14 residents. R31's care plan was not updated to reveal that he no longer had a tracheostomy, or a surgically created breathing hole in his neck. This deficient practice does not paint a clear and current picture of R31, whose care needs change because of this update. This has the potential to affect all residents who graduate from needing a tracheostomy for breathing.

Finding includes:

On 05/10/22 at 10:15 AM, an initial observation of R31 was made in his room. R31 laid in bed and responded softly to his name. R31 did not answer any of State agency's (SA) questions. R31 had a healed tracheostomy site in his neck.

On 05/11/22 at 09:15 AM, R31's electronic medical record (EMR) was reviewed. R31 is a 70-year-old resident admitted to the facility on 03/17/22 with the diagnosis of respiratory failure and low blood oxygen related to a stroke caused by bleeding in the brain. R31's care plan, with care plan review completed on 04/05/22, indicated that R31's problems included a " ...a tracheostomy r/t [related to] impaired breathing mechanics, Date Initiated: 03/17/2022, Revision on: 03/25/2022."

On 05/12/22 at 1:22 PM, RN4 was interviewed at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 11 the nursing station. RN4 stated that R31's care plan problem of having a tracheostomy was resolved and it should have been updated on his care plan. On 05/13/22 at 3:35 PM, the facility's "Goals and Objectives, Care Plans" policy "Version 1.0 (H5MAPL0353)" was reviewed. It stated, " ...5. Goals and objectives are reviewed and/or revised: a. When there has been a significant change in the resident's condition; ..."	F 657		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure appropriate pain management for one resident (Resident (R)132) sampled. There were no medications ordered to treat severe pain and the scale implemented to rate the resident's level of pain was not appropriate for the resident's cognitive status. As a result of this deficiency, the resident is at risk for unrelieved pain, the potential for harm, and potential psychosocial harm. Findings include: R132 was admitted to the facility on 05/06/22 with diagnosis that include a fractured left femur and Dementia.	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 12	F 697		

On 05/10/23 at 10:28 AM, this surveyor heard R132 yelling in her room, "I'm going to die, I'm in pain, help". This surveyor entered the resident's room and staff informed me that the resident had a fractured femur. Observed the resident grimacing, she appeared to be in a lot of pain. At 10:41 AM, the resident continued to yell out in pain. On 05/10/22 at 12:35 PM, this surveyor attempted to conduct an interview with R132. R132 asked this surveyor if I was her daughter and was not alert and oriented to person, place, time, or situation.

On 05/12/22 at 08:30 AM, conducted a record review of R132's Electronic Medical Record (EMR). Review of R132's active physician orders documented an order for Lidocaine Patch 5%; Acetaminophen Extra Strength Tablet 1000 milligrams (ml) two times a day; Acetaminophen 650 mg every 4 hours as needed for Mild Pain; and Nacro (Hydrocodone-Acetaminophen) Tablet 5-325 mg one tablet every 6 hours as needed for moderate pain (5-7) related to the resident's left femur fracture. There were no physician orders for treatment of severe pain. There was a physician order for the use of the Universal Pain Assessment Tool every shift, on a scale of 1 to 10 where 0= no pain, 5= moderate pain, 10= worst possible; 0= no pain, 1 to 3= mild pain, 4-6= moderate pain, and 7-10 = severe pain. A review of the resident's care plan documented only the Universal Pain Assessment was implemented to rate and report R132's pain level.

On 05/13/22 at 10:34 AM conducted a concurrent record review of R132's EMR and interview with the Director of Nursing (DON). After reviewing R132's physical orders, current medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 13 orders, care plan, and progress notes, the DON confirmed there were no interventions to treat severe pain and the Universal Pain Assessment tool was the only pain scale used for R132. Inquired if R132 is capable of accurately reporting the level of pain. The DON confirmed R132 is unable to accurately use the Universal Pain Assessment tool to report her pain level and the use of the Wong Baker Pain scale (uses pictures of faces with expressions, numbers, and simple descriptions to describe the pain level (i.e. 0 = No Hurt; 2 = Hurts Little Bit, 4 Hurts Little More, 6= Hurts Even More, 8 = Hurts Whole Lot, 10 = Hurts Worst) would be more appropriate for R132 due to the resident's cognitive status. Review of the facility's policy and practices on Pain Management documented under Pain Assessment the facility will use a pain assessment tool, which is appropriate for the resident's cognitive status to assist staff in consistent assessment of a resident's pain.	F 697		
F 755 SS=E	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	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 14	F 755		

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 observations, staff interview and review of policy, the facility failed to identify and discard the following treatment medications: Skintegrity Hydrogel, 3% Hydrogen Peroxide. As a result of this deficiency, the facility put the residents at risk for exposure to the expired treatment medications and possible side effects.

Findings include:

On 05/10/22 at 10:10 AM, an observation of the Treatment Cart on the second floor nursing unit revealed the following: Skintegrity Hydrogel 4oz. Tubes with an expiration date 3/22, Hydrogen Peroxide 3%, 4oz bottles with an expiration date 03/20/22.

During staff interview on 05/10/22 at 10:45 AM, Assistant Director of Nursing (ADON) was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 15 queried about the expired medications previously listed. ADON acknowledged that the medications were expired and proceeded to discard them. ADON also stated that pharmacy had recently checked the cart and should have seen the expired medications. Review of facility policy on Storage of Medications read the following: Policy Statement, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation, 1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received ... 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.	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	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 16	F 812		

serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, and record review, the facility failed to use the correct metric to document the temperatures of a nursing unit's nourishment refrigerator for their residents. The staff did not recognize that the refrigerator temperature fell out of the acceptable range which could potentially have caused the food to spoil, injuring their residents. This deficient practice could affect all residents of the facility.

Finding includes:

On 05/12/22 at 12:00 PM, an observation of the nourishment refrigerator for residents on a nursing unit was made. "6" was noted to be on the digital display for temperature and it was verified with the DON. It was determined by the DON that the temperature was in Celsius as indicated by a marking on the digital display.

A concurrent observation and interview with the DON were done after the visual verification of the current refrigerator temperature was done. It was confirmed that the temperatures on the "Nourishment Refrigerator (sic) Log" from 7:00 AM on February 9, 2022, to 7:00 AM on May 12, 2022, were documented in Celsius instead of as indicated on the bottom left of the log, "Fridge temp range 36-46 degrees Fahrenheit." The logs for March 2022 to April 2022 were also labeled as the "Medication Refridgerator (sic) Log" but the DON confirmed that these were the nourishment refrigerator logs. The DON stated that the temperatures were checked twice a day at 7:00 AM and 7:00 PM. She verified that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 17 temperatures should have been logged in Fahrenheit and not in Celsius, so that outlying temperatures could be easily confirmed. She further stated that the nurse was supposed to call or send a "TELS" communication via email to the Maintenance department once the problem was discovered. The "Nourishment Refridgerator (sic) Log" for February 2022 revealed that the Maintenance department was notified four times. On 05/12/22 at 12:10 PM, a concurrent observation and interview with the Director of Maintenance (DM) was done on the nursing unit. DM stated that for any maintenance problems, he would receive a phone call from the nurse or an email through the facility's "TELS" system. State Agency (SA) asked for, but was not provided, any maintenance problems logs and repairs done for the nurse's reports about the wrong metric on the nursing unit's nourishment refrigerator. On 05/13/22 at 11:00 AM, further review of the facility's February 2022 to May 2022 "Nourishment Refridgerator (sic) Log" was done. The range of temperatures in Celsius were from one degree to 11 degrees. 11 degrees Celsius converted to Fahrenheit on Google.com is equal to 51.8 degrees. On 05/13/22 at 3:40 PM, the facility's policy, "Refrigerators and Freezers" "Version 1.0 (H5MAPL0721)" was reviewed. It stated, " ...1. Acceptable temperature ranges are 36ºF [degree Fahrenheit] to 46ºF [degree Fahrenheit] for refrigerators ..."	F 812		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 18 §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of policy, the facility failed to identify and maintain a clean Medication Refrigerator located on the 3rd floor. As a result of this deficiency, the facility put the residents and/or staff at risk for exposure to the unsanitary environment. Findings include: On 05/12/22 at 08:30 AM, an observation of the Medication Refrigerator on the third floor nursing unit showed a black dirt looking substance along the upper rubber seal. The substance extended along most of the upper rubber seal. On 05/12/22 at 08:35 AM, Registered Nurse (RN) 3 was queried and acknowledged that the black dirt looking substance was there along the upper rubber seal. RN3 said that they would look into it and/or take care of it. A review of facility policy on Cleaning and Disinfection of Environmental Surfaces read the following: Policy Statement, Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA bloodborne pathogens standard. Policy Interpretation and Implementation ... 3. Devices that are used by staff but not in direct contact with residents (e.g. computer keyboards, PDAs, etc.) shall be cleaned and disinfected regularly (according to facility schedule) by the environmental services staff and as needed by	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 19 the nursing staff ... 9. Housekeeping surfaces (e.g. floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled, 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g. daily, three times per week) when these surfaces are visibly soiled...	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING _____ B. WING _____	05/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The facility was found in compliance with Section 483.73, Requirement for Long Term Care (LTC) Facility Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual.	E 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**05/11/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: K-761 Maintenance, Inspection and testing-Doors This STANDARD is not met as evidenced by: Based on record review and staff interview with the facility manager, the facility failed to produce documentation for an annual inspection for the fire doors in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, sections 5.2, and 5.2.3. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of an annual inspection to ensure proper protection from fire and smoke extension within the facility. Findings include: During facility observation on 5/11/22 at approximately 1:15 pm revealed that the facility failed to provide documentation for the annual fire door inspection. These findings were verified at the exit conference with the facility manager and Administrator on 5/11/22 at 2:30 pm.	K 761		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**05/11/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 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	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**05/11/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 2 System Maintenance and Testing This STANDARD is not met as evidenced by: Based on record review and staff interview with the facility manager, the facility failed to produce documentation for an annual testing of diesel fuel in accordance with NFPA 99 Healthcare Facilities Code, 2012 edition, section 6.5.4, and NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition, section 8.3.8. This deficiency could affect all residents, staff, and visitors during an interruption of grid power due to the lack of an annual diesel fuel test to ensure proper operation of the standby power system. Findings include: During record review on 5/11/22 at approximately 12:30 pm revealed that the facility failed to provide documentation for the annual diesel fuel test. These findings were verified at the exit conference with the facility manager and Administrator on 5/11/22 at 2:30 pm.	K 918		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	125067	A. BUILDING: _____ B. WING _____	5/11/2022

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: E-004 Emergency Prep This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) document in accordance with Appendix Z of the State Operations Manual (SOM) and 42 CFR 483.73 for long term care facilities. Proof of an annual review was not documented. This deficiency could affect all residents, staff, and visitors during an emergency due to the lack of the required updates which would maintain current details of the facility EPP. Findings include: During record review on 5/11/22 at approximately 1:30 pm revealed that the facility's Emergency Preparedness Plan was not reviewed and updated during the past year which is not in accordance with Appendix Z of the SOM and 42 CFR 483.73. These findings were verified at the exit conference with the facility staff members on 5/11/22 at 2:30 pm.

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

The above isolated deficiencies pose no actual harm to the residents