STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125057	A. BUILDING _____ B. WING _____	03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULANA MALAMA	91-1360 KARAYAN STREET EWA BEACH, HI 96706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on March 18, 2021. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. One complaint was investigated Aspen complaint tracking system (ACTS) #8018 and was not substantiated. The highest scope and severity (S/S) = G for F686 Treatment/Svcs to prevent/heal pressure ulcers. Survey dates: March 16 to 18, 2021. Survey Census: 27. Sample size: 12.	F 000		
F 686 SS=G	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 observation, interview and record review, one Resident (R)5 acquired a stage four pressure injury while residing in the facility. In	F 686	Staff were called together to discuss findings for Resident #5 and to provide education on the importance of following	4/19/21

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

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F 686	Continued From page 1 spite of the appropriate and timely wound treatment, and dietary interventions to address the wound, progressed to a stage four pressure ulcer of the coccyx. Surveyor made multiple observations from 03/16/21 to 03/18/21 and noted that R5 was lying in the same position for a minimum of three to three and one half hours. Timely turning and repositioning of the resident is crucial to promote wound healing and avoid continuous pressure on the existing injury. The deficient practice resulted in poor healing and worsening of the stage four coccyx injury and R5 was subjected to painful treatment and acquired infections that exacerbated the treatment outcome. The deficient practice failed to provide R5 with the highest practicable physical well being while residing in the facility. Findings include: Surveyor reviewed the electronic medical record (EMR) on 03/16/21 at 4:54 PM. Per the wound weekly observation tool dated 03/12/21 at 15:02, resident has a stage four pressure injury to the coccyx that is facility acquired. 1.8 cm L X 1.0 cm wide X 1.5 cm deep. Undermining from two to three o'clock position, with pink tissue. Current treatment and dressing provided. R5 is a disabled, male adult resident totally dependent on staff for bed mobility. Surveyor reviewed the EMR on 03/17/21 at 11:49 AM. Progress notes dated 09/02/20 17:42. Skin: Skin warm & dry, resident has current skin issues. Pressure Ulcer/ Injury. Skin issue Location: Coccyx Pressure Ulcer / injury Stage IV full thickness tissue loss. Wound Bed: Granulation. Wound Exudate: Serosanguineous.	F 686	protocol for wound care treatment. (03/18/21) Audits were started for positioning resident, every 2 hours x 2 weeks, then 3 x a shift for 1 week, then 1 x a shift for 1 week, then spot check. (03/18/21) An education board was created for staff to read concerning citations. (03/19/21) A reposition sensor that integrates with our life support systems was applied for two days on a trial basis. Although the sensor seemed promising, the cost was deemed too high for the product. (03/19/21) A written test was created and given to nursing staff on pressure ulcer prevention. (03/22/21) A section on repositioning documentation every 2 hours was added to the PointClickCare system (EMR). (03/23/21) Ordered wedges for positioning the resident and started using. (04/14/21) Wound consultant and DON contacted bed representative for recommendations for a positioning system to prevent shearing the resident. (04/19/21) All residents were checked to identify any other pressure injuries that were not attended to properly. None were found. (03/19/2021)	

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F 686	Continued From page 2 Peri Wound Condition: Fragile. Dressing saturation: Minimal (<25%). No wound odor. Tunneling present. Undermining noted. Clinical suggestions: Evaluated for pain, discomfort. Dressing changes/treatments performed as ordered. Resident is turned, ambulated, moved at least every 2 hours. Surveyor observed R5 in his hospital bed in the primary activity area on 03/17/21 at 12:47 PM. Noted head and shoulders facing to the right, on his back. The Registered Nurse (RN) 1 stated that she will do his dressing change around 2 PM after she give's his suppository and he has his bowel movement (BM). 03/17/21 at 01:25 PM R5 was in his bed in his room head and shoulders facing to the left side. Per RN, she just gave the suppository, and will change the dressing after his BM. Surveyor made the following additional observations on 03/17/21: 2:30 PM, same position, facing to his left side. 3:07 PM, same position, facing left side. 3:40 PM same position, facing left side. 430 PM facing left side. Surveyor received and reviewed thinned paper progress notes on 03/17/21 at 12:50 PM. 11/09/19. Daily skilled nurse's note. Coccyx wound closed with pinpoint scab. 11/29/19. Coccyx wound dressing changed after bath. Scant amount of purulent drainage noted to old dressing, no odor, no s/s infection. 12/05/19. No change to care of pressure ulcer coccyx wound, dressing changed, wound culture ordered and sent, pending results. 12/09/19. New order for Bactrim DS via GT BID x	F 686	Facility will continue to do weekly skin checks by the licensed staff. Normally occurs on Wednesdays. (03/24/21) Any identifying skin issues will be reported to the attending physician, and if necessary, will consult the wound consultant. Audits for positioning will be done weekly x 4 weeks, then bi-weekly x 1 month, then monthly x 3 months, then periodically spot checked. (03/24/21) Any issues or discrepancies will be brought to the QAPI Committee for further evaluation and follow up. (04/23/21 and ongoing)	

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F 686	Continued From page 3	F 686		

14 days, diagnosis (DX): Coccyx wound infection.

03/19/20. Coccyx wound bed continues pink, no drainage, no signs symptoms of infection. Per wound consultant, coccyx wound closed with fragile scar tissue.

04/23/20. Seen by wound consultant (WC) measured 0.4 cm X 0.2 CM 0 0.2 cm with signs of improvement.

05/14/20. WC, coccyx wound perimeter with maceration, wound bed is with dark pink tissue, wound measurement 0.5 cm x 0.2 cm depth 0.3 cm, mom was updated with new order of the coccyx wound treatment.

06/04/20. New order for new coccyx wound treatment (tx) due to (d/t) worsening. New measurements 1.1 cm L x 0.4 cm w X 0.3 cm D.
06/18/20: Wound consultant came by today, coccyx wound measures 1.1 x 0.6 cm.

07/09/20: Coccyx wound continues with slight opening, blood noted to old packing strip, New order for Ciprofloxacin, & intravenous (IV) Ampicillin. and Lidocaine for debridement. Coccyx wound measures 0.9 cm x 0.8 cm x 0.4 cm. with undermining.
07/30/20: Debridement to coccyx wound. remove dead tissue.

08/06/20: Coccyx wound with soft eeschar noted. wound bed 1.4 cm X 1.2 cm. Depth 0.5 cm. underminined with 3 o ' clock 0.2 cm.
08/15/20: Coccyx wound was debrided by WC, measured 2.7 cm X 1.5 cm X 0.7 CM x 0.6 cm underming to 2 o ' clock. New order for coccyx wound.

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F 686	Continued From page 4	F 686		

08/17/20: WC came to debride residents coccyx wound, measurements 2.9 cm x 2.8 cm x 0.8 cm. Labs ordered DX: Chronic wound.

Surveyor reviewed the Registered Dietician (RD) notes on 03/17/21 at 2:52 PM.
11/29/20 nutrition/dietary note. Resident is at risk for poor wound healing his nutrition needs to be maximized without causing excessive weight gain. Goal to provide appropriate nutrition and hydration for optimal health with total G-Tube (GT) feeds. Maintain weight between 58-61 kilograms (kg). P: Continue with Peptamen 1.0 at 250 milliliters (ml) x 4 day at 125/ml per hour. Continue with Arginaid 1 packet day continue with Beneprotein 2 packets continue with multivitamin.

12/19/20 Nutrition/dietary note.
Recommendation. Start 1 packet of Juven/day.

02/27/21 Nutrition/ Dietary Note: Resident appears stable in weight. He has been stooling 1-2 x day no loose stools noted. Continue current plan.

Surveyor observed R5 on 03/18/21 at 07:06 AM lying on his left side with pillows propped on his side and between his knees.
Surveyor made the following additional observations on 03/18/21:

08:00 AM, R5 facing to the left looking toward the window with his neck hyperextended.
08:40 AM R5 in same position facing to the left looking toward the window with his neck hyperextended.
09:33 AM R5 in same position facing to the left looking toward the window with his neck hyperextended.

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F 686	Continued From page 5	F 686		

10:21 AM R5 in same position facing to the left looking toward the window.

Surveyor observed a dressing change on 03/18/21 at 10:29 AM Present were RN2 Marilyn, Director of Nursing (DON), and the wound care nurse consultant by cell phone face time so she was able to watch and assess the wound while RN2 did the dressing change. Surveyor asked RN2 what are the interventions nursing staff are doing to prevent worsening of the pressure ulcer, she replied that the wound nurse sees him weekly and the RN and certified nurse aide (CNA) are turning him every two hours..
The DON added that R5 also has a pressure relieving mattress. We are turning him side to side at least every two hours. he is also on Juven (a formula to promote wound healing).
Surveyor asked if the resident has pain, if so, how is it being treated. The RN2 replied that he isn't having any pain now. The WC stated when we debride the wound he receives pain medicine via the G-tube and lidocaine topically.
Surveyor asked the WC when did the current pressure ulcer (PU) develop and what caused the PU. The WC replied it started In August of 2019. R5 has been challenged because of bacteria that enters the wound during his frequent bowel movements. He has been on a few different antibiotics for infection. The area on the coccyx was open previously. Every week I'm doing a sharp debridement of the wound that seems to be helping, then thought we had some problems with protein issues. He is now on a vitamin D supplement. A big issue is he has quite a few BM's in a day. The staff are doing a good job putting that dressing on, and are able to keep the feces out of the wound.
Surveyor asked what are the interventions to

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F 686	Continued From page 6 prevent the wound from worsening and improve. The WC replied, no shearing, when the nursing staff are rolling him they need to avoid pulling him up on that wound. Keep the dressing clean and no feces in the wound bed. We did get the Dietary consult and the RD adjusted his nutrients to include more protein and vitamin D. Keep him clean and dry, making sure the dressing is intact. If staff notice a sign of infection they are to report it to the DON and Wound nurse immediately. Surveyor asked how important it is to turn R5 every two hours, she stated that it is very important. Surveyor asked if the pressure ulcer is preventable and she said yes I would say it is. In this case very challenging to do but preventable. Surveyor asked what interventions were in place before the PU developed. The WC replied turning him regularly and keeping him clean. Surveyor noted at 10:40 AM R5 was turned onto his right side for the dressing change. At 11:57 AM, noted staff brought R5's bed out to the activity area, where he was facing to the right side. Surveyor made the following additional observations on 03/18/21: 12:45 PM R5 in same position in his bed facing the right side. 1:34 PM R5 in same position facing to the right side. 1:53 PM R5 is back in his room, same position facing to the right side.	F 686		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,	F 921		4/23/21

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F 921	Continued From page 7 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to properly store an oxygen cylinder (O2 tank) in the appropriate storage rack. As a result of this deficient practice, the facility put the safety and well-being of the residents, staff, as well as the public at risk for accident hazards. Findings Include: During observation of an office room on 03/16/21 at 08:00 AM, one O2 tank was noted laying flat on the floor and not properly stored in a designated storage rack. With this O2 tank not being properly stored, there was a possibility of it causing an accident hazard. On 03/17/21 at 09:18 AM, the Director of Nursing (DON) was queried about the O2 tank not being properly stored and the DON acknowledged that the O2 tank should have been properly stored in a designated storage rack. DON immediately picked up the O2 tank and stated that it would be properly stored away.	F 921	The O2 tank was immediately placed on a stand. (03/17/21) The O2 tank was the personal tank of an employee that suffers from a pulmonary condition. At the end of the day, the employee took the O2 tank home. (03/17/21) All personal O2 tanks to be approved by the Maintenance Department before allowing in the office for safety and tags. (03/17/21) All O2 tanks in the facility were checked for proper storage requirements. (04/22/21) All staff were educated on the proper storage requirements for oxygen tanks. (04/21/21) An audit will be done weekly x 1 month for proper storage of oxygen tanks. (04/01/21) Any discrepancies or issues will be brought to the QAPI Committee for further follow up. (04/23/21)	

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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 03/30/21. The Facility was found not to be in compliance with the requirements of 42 CFR 483.70 (a), 2012 Edition of the Life Safety Code for Long Term Care Facilities.	K 000		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exit discharges in four locations are in accordance with CMS S&C letter 05-38 dated 07/24/05. Failure to have a hard surface to the public way can present exit discharge challenges for a person in a wheelchair or a person who has gait problems. This had the potential to the 28 residents who reside in the facility. Findings include: Observation on 03/30/21 at 10:00 AM of the classroom/activities area at the far edge of the building measuring 2520 square feet revealed an exit door discharging to a concrete slab without a	K 271	The Environmental Services Coordinator contacted a contractor (DC Asphalt Services, Inc.) to review and submit a proposal for the planned walkways and paths. The Administrator received the proposal and reviewed it. The proposal was signed off by the Administrator. The Environmental Services Coordinator sent the proposal back to the contractor to begin planning the work to be performed. Construction is estimated to take place over the next two months. This is pending any building permit approvals that need to	7/27/22

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K 271	Continued From page 1 complete hard surface to the public way. After the four feet by four feet concrete slab there is 21 feet of grass to the public way. The facility emergency floor plan posted on the wall describes the door as an exit. An emergency exit only sign is posted on the door. Observation on 03/30/21 at 10:05 AM of the cafeteria area at the far edge of the building revealed an exit door discharging to a concrete slab without a complete hard surface to the public way. After the four feet by four feet concrete slab there is 96 feet of grass to the public way. The facility floor plan labels the door as an exit. The door has an illuminating exit sign above it. Observation on 03/30/21 at 10:10 AM near bedroom 6 revealed an exit door discharging to a concrete slab without a complete hard surface to the public way. After the four feet by four feet concrete slab, there is 114 feet of grass to the public way. The facility floor plan labels the door as an exit. The door has an illuminating exit sign above it. Observation on 03/30/21 at 10:15 AM near bedroom 4 revealed an exit door discharging to a concrete slab without a complete hard surface to the public way. After the four feet by four feet concrete slab there is 114 feet of grass to the public way. The facility floor plan labels the door as an exit. The door has an illuminating exit sign above it. Interview with the Maintenance Director at the time of each of the above observations verified the lack of hard surface to the public way. The code requires under CMS S&C letter 05-38	K 271	be obtained. The Environmental Services Coordinator and Administrator walked the property and checked that every exit door has a hard surface path to the public walkway. Those that do not are covered in the proposal. This was completed on 04/23/21. After completion, all exit discharges will have concrete pathways to the closest sidewalk and/or curb. No additional future exit doors are planned, so there should be no need for further follow up after these pathways are constructed. However, should it come up in the future, the Environmental Services Coordinator and Administrator will ensure proper exit pathway regulations are met.	

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K 271	Continued From page 2 dated 07/24/05 "exit discharges are required to have a hard surface to the public way".	K 271		
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 observation and interview, the facility failed to ensure that two exit signs were continuously illuminating in accordance with NFPA 101 (2012 edition) section 7.10.4 and 7.9.2.7. Lack of proper exit signage could result in occupants being confused as to the location of an exit in a fire emergency. This had the potential to affect the 28 residents who resided in the facility. Findings include: Observation on 03/30/21 at 10:00 AM of the large classroom and activity room revealed a red exit sticker on the door indicating "emergency exit only." The door was lacking an illuminating exit sign. The room was identified as an exit on the emergency floor plan. Interview with the Maintenance Director at the time of the observation verified the door was an exit door.	K 293	1) Upon consultation with the building architect on 04/19/21, it was confirmed and verified on the building blueprint approved by the City and County of Honolulu, Department of Planning and Permitting, that the exit door in the large classroom and activity room referred to in the citation is not an emergency exit door. The exit signage on the door was removed on 04/19/21 to prevent future confusion. 1) In-service and training was provided to all staff regarding changes made on 04/19/21. 1) All signage referencing that door as being an emergency exit have been modified to remove that exit. 1) To ensure ongoing compliance, audits will be conducted by the Environmental	4/19/21

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K 293	Continued From page 3 Observation on 03/30/21 at 10:40 AM of a corridor "number two" off the main corridor revealed a reflective exit sign above an exit access door. There was no illuminating sign above the exit access door. Interview with the Maintenance Director at the time of the observation verified the exit sign above the door was reflective and not continuously illuminating. The code requires under NFPA 101 (2012 edition) section 7.10.4 "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	Services Department to ensure signage is not present during their routine facility inspections. 1) Ongoing monitoring and evaluation will be conducted by Environmental Services Coordinator and Administrator to ensure compliance with this requirement and discussed/addressed in quarterly QAA/QAPI as well as administrative meetings as applicable. 2) The "number two" corridor hallway is not considered an exit based on the building blueprint approved by the City and County of Honolulu, Department of Planning and Permitting. The exit signage on both sides of the door hallway was erroneously requested by Hawaii Occupational Safety and Health Division (HIOSH) during their last inspection. 2) In-service and training was provided to all staff regarding changes made on 04/19/21. 2) All signage referencing that corridor as being an exit have been modified to remove that exit. 2) To ensure ongoing compliance, audits will be conducted by the Environmental Services Department to ensure signage is not present during their routine facility inspections. 2) Ongoing monitoring and evaluation will be conducted by Environmental Services Coordinator and Administrator to ensure	

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	125057	A. BUILDING **02 - KULANA MALAMA** B. WING _____	**03/30/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULANA MALAMA	**91-1360 KARAYAN STREET EWA BEACH, HI 96706**

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K 293	Continued From page 4	K 293	compliance with this requirement and discussed/addressed in quarterly QAA/QAPI as well as administrative meetings as applicable.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke detectors were more than three feet from air diffusers in accordance with NFPA 72 (2010 edition) section A.29.8.3.4 (6). Failure to comply could result in smoke filled air being blown away from smoke detectors. In addition, detectors could build up dirt inside the chamber from the air register resulting in poor performance and smoke detectors could fail to sound an alert. This had the potential to affect all 28 residents who resided in the facility. Findings include: Observation of smoke detectors in patient bedrooms #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 15, 17, a vacant apartment, and supply storage room on 03/30/21 from 10:00 AM to 11:30 AM revealed the smoke detectors were 12 inches from an air diffuser or supply register.	K 345	The facility contacted the fire safety contractor to submit a proposal for relocation of affected smoke detectors. The proposal was received and approved. Fire safety contractor started the work of relocating the affected smoke detectors on 05/16/22. Work was completed 05/18/22. All other smoke detectors were checked for compliance to regulations. To prevent concerns regarding airborne dust and dirt from the diffuser which could cause nuisance alarms, training was provided to all Environmental Services staff regarding frequent assessment/cleaning of smoke detectors	5/18/22

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K 345	Continued From page 5 Interview with the Maintenance Director at the time of the observation verified the distance to the smoke detector from an air diffuser or supply register. The Maintenance Director confirmed that the registers were supply registers. The code requires under NFPA 72 section A.29.8.3.4 (6) "smoke alarms and smoke detectors shall not be installed within 36 inches horizontal path from supply registers of a forced air heating or cooling system and shall be installed outside of the direct airflow from those registers."	K 345	on 07/07/21. To ensure ongoing compliance, audits will be conducted by the Environmental Services Department staff to ensure frequent maintenance of smoke detectors during their routine facility inspections and documented. Ongoing monitoring and evaluation will be conducted by Environmental Services Coordinator and Administrator to ensure compliance with this requirement and discussed/addressed in quarterly QAPI/QAA as well as administration meetings as applicable.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	K 351		7/7/21

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K 351	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure sprinklers were installed to provide complete coverage in one location in the central corridor in accordance with NFPA 13 (2010 edition) section 8.1.1.(1) and 8.15.7.1. Failure to provide complete sprinkler coverage could lead to a fire progressing further and faster without being extinguished. This deficient practice had the potential to affect all 28 residents who resided in the facility. Findings include: Observation on 03/30/21 at 10:45 AM revealed a 21-foot-long by 11-foot-wide nursing station in the center of the corridor with a vaulted glass ceiling 30 feet above with a pergola type roof. Above the pergola was two layers of plastic extending over the entire roofing surface. The sprinklers are above the ceiling to the nursing station. During an interview at the time of the observation the Maintenance Director stated the nurses were concerned that the glass vaulted ceiling could break in severe weather bring the glass down on top of them. The Maintenance Director agreed the plastic would disrupt sprinkler coverage inside the nursing station. The code requires under NFPA 13 (2010 edition) section 8.1.1. that "sprinklers shall be installed throughout the premises."	K 351	The facility removed the tarp covering the nursing station on 04/12/21. Since tarp was removed, original design was reinstated and existing fire suppression systems should sufficiently cover the affected area. Environmental Services Coordinator was educated by the Life Safety Surveyor on the day the citation was discussed. Training will be provided to all staff on 07/07/21 with assurance that the glass above the nursing station is secure and in the event of a major disaster all staff, residents and important documents maintained at the station would be removed consistent with disaster preparedness protocols. To ensure ongoing security of glass / roof, audits will be conducted by the Environmental Services Department staff to ensure glass and roof is secure with integrity intact. Ongoing monitoring and evaluation will be conducted by Environmental Services Coordinator and Administrator to ensure compliance with this requirement, not creating enclosed spaces which need to be sprinklered, and discussed in quarterly QAPI / QAA as well as stand-up meetings as applicable.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		7/7/21

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K 353	Continued From page 7 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on review of sprinkler system testing reports and interview, the facility failed to ensure that quarterly sprinkler inspections were conducted in accordance with NFPA 25 section (2011 edition) table 5.1.1.2. Lack of sprinkler inspections and testing can result in problems with the system not being identified or resolved. As a result, the sprinkler system may not function correctly. This had the potential to affect all 28 residents who resided in the facility. Findings include: Review of sprinkler contractor records revealed an annual report from a certified contractor dated 01/22/21. No other certified sprinkler contractor reports were available in the past 12 months. The facility had sprinkler checks done in house or	K 353	The facility contracted a licensed and certified fire sprinkler inspection company on 04/16/21 to perform the required quarterly inspections. The initial quarterly inspection was conducted on 05/16/21 by Allstate Fire Protection. In-service training of all personnel within the Environmental Services Department will be provided on 07/07/21. To prevent recurrence of this deficiency, the Environmental Services Coordinator will ensure inspections are conducted as per requirements. Any deviations from normal expectations will be reviewed with the Administrator and required repairs will be performed on a timely basis as per	

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K 353	Continued From page 8 by uncertified maintenance employees on 03/10/21, 09/05/20 and 12/11/20. Interview with the Maintenance Director on 03/30/21 at 11:30 AM revealed his staff have done the inspections and the facility "probably needs to have the contractor complete the reports in the future." The code requires under NFPA 25 (2011 edition) table 5.1.1.2 "on a quarterly basis the waterflow device, alarm devices associated with the sprinkler system, and the valve supervisory system devices shall be checked. The annual inspection requires bracing inspections, pipes and fittings, and all sprinkler heads."	K 353	facility policy. Ongoing monitoring and evaluation will be conducted by Environmental Serv9ices Coordinator and Administrator to ensure compliance with this requirement and discussed in quarterly QAPI/QAA as well as stand-up meetings as applicable.	
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	K 363		5/14/21

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K 363	Continued From page 9 impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that five of the bedroom corridor doors were without impediments to closing or prevent the passage of smoke into the corridor in accordance with NFPA 101 (2012 edition) section 19.3.6.3. Corridor doors that do not prevent smoke travel will allow smoke to enter the exit corridor. This had the potential to affect eight residents in the five bedrooms. Findings include: 1. Observations of bedroom #6, #3, and #12 on 03/30/21 from 10:10 AM to 10:30 AM revealed the doors would not close and remained ajar after the surveyor attempted to close each door. Interview with the Maintenance Director at the time of the observations verified the doors were	K 363	1) The facility maintenance department inspected doors leading to rooms #3, 6, and 12. It was found that the magnetic latch was not adhering properly once the doors were closed. (04/14/21) 1) The magnetic latch was replaced and tested to ensure the doors remained closed. (04/14/21) 1) All doors, with the exception of door #5, were tested to ensure proper latching once closed. See citation #2 for explanation of door #5. (04/14/21) 1) The Environmental Services Coordinator was educated by the Life	

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K 363	Continued From page 10 ajar and would not remain closed. 2. Observation of bedroom #5 on 03/30/21 at 10:15 AM revealed while the surveyor was closing the door, the door had an impediment to closing at the floor. The door was dragging on the floor leaving marks from the door in the linoleum. Interview with the Maintenance Director at the time of the observation verified the door had an impediment to closing. 3. Observation of bedroom #17B on 03/30/21 at 11:05 AM revealed the door had an impediment to closing. When closing the door, the surveyor noted the door hit a desk corner preventing the door from closing. The door was open 12 inches due to the desk impediment. The code under NFPA 101 (2012 edition) section 19.3.6.3.1 states, "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 shall be constructed of materials that resist fire for a minimum of 20 minutes." The code Under NFPA 101 (2012 edition) section19.3.6.3.5 states "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, the device shall be capable of keeping the door fully closed if a force of five pounds of pressure is applied."	K 363	Safety Surveyor on the day the citations were discussed. The Environmental Services Department will check the doors monthly to ensure properclosure and retention. (05/14/21 and ongoing) 1) Any discrepancies will be brought to the attention of the Administrator, and the QA Committee if necessary. (05/14/21 and ongoing) 2) Room #5 door was adjusted by the Environmental Services Director; however, after adjustment, it was found that the door still would not close completely. (04/09/21) 2) Door contractor was called and inspected the door for any options the facility may have to ensure proper closure. (04/09/21) 2) Door contractor will adjust the door per recommendation to ensure proper closure and latching. (05/09/21) 2) Room #5 door will be tested monthly, along with the other doors for proper closure and retention, once repairs are done to the door. (05/09/21) 2) Any discrepancies will be brought to the attention of the Administrator, and the QA Committee if necessary. (05/09/21 and ongoing)	

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K 363	Continued From page 11	K 363	3) The desk in room #17 was moved to allow proper closure of the door. (04/14/21) 3) All doors, with the exception of door #5, were tested to ensure proper latching once closed. See citation #2 for explanation of door #5. (04/14/21) 3) The Environmental Services Coordinator was educated by the Life Safety Surveyor on the day the citations were discussed. The Environmental Services Department will check the doors monthly to ensure proper closure and retention. (05/14/21) 3) Any discrepancies will be brought to the attention of the Administrator, and the QA Committee if necessary. (05/14/21 and ongoing)	
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	K 915		6/7/22

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K 915	Continued From page 12 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. 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). Lack of proper essential electrical system could result in power failure in one part of the building, affecting power to the resident bedroom outlets. This has the potential to affect all 28 residents who resides in the facility including the 22 residents who are on life support ventilation machines. Findings include: Interview with the Director of Nursing on 03/30/21 at 9:55 AM revealed the facility has 22 patients on life support. Observation of the facility generating room or electrical room on the lower level of the facility on 03/30/21 at 10:45 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. Interview with the Maintenance Director at the time of the observation verified the facility has only one transfer switch. Interview with the generator contractor who was maintaining the generator at the time of the observation, also verified the facility has one transfer switch.	K 915	The Environmental Services Coordinator contacted an electrical engineer to verify the electrical load that the facility utilizes. The electrical engineer (MK Engineering) recommended we contract with a local electrician, A-1-Alectrician, Inc. to monitor the electricity load of the facility. A proposal was received and accepted. The electrician has placed his monitoring equipment and will be back on June 2, 2022, to gather the meter readings. After his meter readings are compiled, the electrician will forward the results to the electrical engineer to review and develop a report to the facility Administrator. This is expected to occur no later than a few days after the readings are received. Once the facility Administrator gets the report from MK Engineering, the determination will be made whether a second transfer switch is required under the life safety regulations. If a second transfer switch is required, the facility Environmental Services Coordinator will contact a company capable of installing a secondary transfer	

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K 915	Continued From page 13 The code requires under NFPA 99 (2012 edition) section 6.3.2.2.10.1. "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 requires under NFPA 99 (2012 edition) section 6.4.2.2.1.1. a Type I EES "the EES shall be divided into the following three branches: 1) Life Safety, 2) Critical, 3) Equipment. The code requires under NFPA 99 (2012 edition) section 6.4.2.2.1.2. a Type I EES "the division between the branches shall occur at transfer switches where more than one transfer is required." The code requires under NFPA 99 (2012 edition) section 6.4.2.2.1.3. that a Type I EES "each branch shall be arranged for connection within time limits specified in this chapter" (10 seconds). The code requires under NFPA 99 (2012 edition) section 6.4.2.2.1.4. that a Type I EES "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 150kva or (120KW) or less."	K 915	switch and secure a proposal for the installation. If a second transfer switch is not required, the facility will continue to utilize the current set up. If there is any additional equipment that the Environmental Services Coordinator feels is a significant draw on the capabilities of the generator, he will order another meter testing through a local electrician. The necessity for further action will be determined at that time.	

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E 000	Initial Comments The facility was found to be in compliance with section 483.73 Requirement for Long Term Care (LTC) facility Appendix Z Emergency Preparedness for all provide and certified supplier types, State Operations Manual.	E 000		

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

Electronically Signed | 04/22/2021

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