STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125045	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE ANUENUE RESTORATIVE CARE	**1333 WAIANUENUE AVENUE** **HILO, HI 96720**

(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 000	INITIAL COMMENTS A Life Safety Code survey was conducted by the Office of Health Care Assurance (OHCA) on 12/01/2022-12/02/2022. The facility did not meet the requirements of National Fire Prevention Association (NFPA) 99, Health Care Facilities Code and NFPA 101, Life Safety Code, Chapter 19, Existing Health Care Occupancies, 2012 Edition. Survey date: 12/01/2022-12/02/2022 Census: 90	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to maintain paths of egress to be continuously free of obstructions on 2 (300 Hall and 500 Hall) of 6 halls. This failed practice had the potential to affect 15 residents who resided on the 300 Hall and 29 residents who resided on the 500 Hall, in the event of an emergency. Findings included: Review of a facility policy titled, "Corridor and	K 211	1. The Maintenance Director removed the arm chair and wheelchair during the tour. 2. No other resident had a potential to be at risk since no other chairs or wheelchairs were noted in the resident corridors. 3. Education will be provided to all staff regarding their responsibility to keep the corridors unobstructed. New hires will receive education regarding this expectation during orientation. .	12/23/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/28/2022

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

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K 211	Continued From page 1 Stairway Safety," dated as reviewed on 04/22/2022, revealed, "Standard To ensure that the fire plan can be implemented quickly if needed by keeping all stairwells and corridors clear of obstacles, that signs are in place in stairwells identifying the store, and that emergency lighting is in place." Observation on 12/01/2022 at 1:33 PM revealed the 300 Hall corridor was being used to store a chair. An observation on 12/02/2022 at 1:52 PM revealed the 500 Hall corridor was being used to store a high back wheelchair, which was positioned immediately in front of the exit. During an interview on 12/02/2022 at 12:37 PM, the Director of Maintenance (DOM) revealed he was aware of the requirement that egress cannot be obstructed. The DOM further revealed it was the responsibility of all staff to ensure the paths of egress were not blocked. He revealed he made rounds to observe for obstructed egress and educated staff when he found issues. During an interview on 12/02/2022 at 12:46 PM, the Director of Nursing (DON) revealed she was aware of the requirement to keep the hallways clear of obstructions. The DON indicated she expected the emergency egress to be kept unobstructed. During an interview on 12/02/2022 at 12:49 PM, the Administrator revealed she was aware of the requirement to keep hallways clear of obstructions. The Administrator indicated she expected the emergency egress to be kept unobstructed.	K 211	4. The Maintenance Director, or designee will monitor for compliance weekly for the next 90 days and provide a summary of the audits at the monthly QAPI meeting. The QAPI Committee will determine if substantial compliance has been achieved and the frequency of ongoing monitoring.	

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K 211	Continued From page 2 National Fire Protection Association (NFPA) 101 Means of Egress: General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the	K 363		12/23/22

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K 363	Continued From page 3 smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the entry doors to 1 of 1 kitchen and 1 of 1 central supply room located off the kitchen would self-close without impediment to prevent the potential spread of smoke in the event of a fire. This had the potential to affect one smoke compartment on the ground floor, with no residents residing on that floor. An observation on 12/01/2022 at 1:24 PM revealed the entry door to the kitchen was propped in the open position with a wedge, which impeded the closure of the door in the event of a fire. An observation on 12/01/2022 at 1:26 PM revealed the entry door to the central supply room, which contained combustible materials, was propped in the open position with a rock wedge, which impeded the closure of the door in the event of a fire. In an interview on 12/02/2022 at 1:02 PM, Dietary Employee (DE) #8 revealed he knew that fire barrier doors were not allowed to be impeded with a wedge.	K 363	1. No residents were identified to have been impacted because the findings were in a nonresident compartment in the facility service area. 2. No other residents were identified to have been impacted because the findings were in a nonresident compartment in the facility service area. 3. Education will be provided to all staff regarding their responsibility to ensure no doors are propped open and can be closed with one motion if open. New Hires will receive education regarding this expectation during orientation . 4. The Maintenance Director, or designee will monitor for compliance weekly for the next 90 days and provide a summary of the audits at the monthly QAPI meeting. The QAPI Committee will determine if substantial compliance has been achieved and the frequency of ongoing monitoring.	

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K 363	Continued From page 4 In an interview on 12/02/2022 at 12:39 PM, the Director of Maintenance (DOM) revealed he was aware that wedges would prevent the closure of the door in the event of fire. He expected the doors not to be impeded from closing. He indicated all staff were responsible for ensuring fire/smoke doors were not impeded with wedges to prevent closure. In an interview on 12/02/2022 at 12:47 PM, the Director of Nursing (DON) revealed she was not aware that wedges would prevent the closure of the door in the event of fire. She expected the doors not to be impeded in the event of fire. In an interview on 12/02/2022 at 12:49 PM, the Administrator revealed she was aware that wedges would prevent the closure of the door in the event of fire. She expected the doors not to be impeded from closing. She revealed it was the responsibility of all staff to ensure doors would close in the event of fire.	K 363		