

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125007	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Hale Makua - Kahului		STREET ADDRESS, CITY, STATE, ZIP CODE 472 Kaulana Street Kahului, HI 96732	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on observations, record review (RR) and interviews, the facility failed to provide incontinence care, in accordance with professional standards of practice and individual care plans (CP) for two resident's (R)1 and R2, of a sample size of seven. As a result of this deficient practice, the residents were at increased risk of adverse outcomes related to incontinence that included comfort, skin breakdown and infection. This could affect their ability to meet their highest potential of physical and mental well-being. The deficient practice had been corrected prior to the survey, and met the criteria for past noncompliance. Findings include: 1) The Office of Healthcare Assurance (OHCA) received a completed facility incident report on 02/29/2024 regarding incontinence care. On the evening of 02/24/2024, a CNA (Certified Nurse Assistant)1 reported two residents (R1 and R2) were allegedly not provided incontinent care by CNA2, scheduled on the day shift. R1 is a [AGE] year old female admitted to facility on 06/09/2023 with primary diagnosis of nontraumatic intracerebral hemorrhage, with hemiplegia (paralysis) and hemiparesis (weakness). She is incontinent and has moderate cognitive impairment as evidenced by a BIMS (Brief Interview for Mental Status) score of 8/15. R2 is a [AGE] year-old admitted to facility on 09/21/2020 with primary diagnosis of vascular dementia with mood disturbance, depression and anxiety. She is incontinent and has moderate cognitive impairment as evidenced by her BIMS score of 8/15. CNA2 was accused of allegedly failing to provide incontinent care to the residents listed in the report and suspended on 2/24/23, until conclusion of the investigation. The investigation was documented as ongoing. 2) The facility provided all investigation documents, which included: Administrator conducted interview dated 02/24/2023. Per Staff Certified Nurse Assistant (CNA)1: At 3:30 PM I was completing my rounds When I got to room [ROOM NUMBER]B I noticed that the resident was not changed and the bed pad was wet. Staff continued to express I changed residents brief and I notified Nurse to witness what had happened. Administrator conducted interview dated 02/24/2024. Per Staff Licensed Nurse (LN)1: At 1520 (03:20 PM) CNA1 came to me and said she had just changed 115B (R1) and was going to change 114B (R2). She stated both residents' briefs were soaked. I told her I wish she had told me. She (CNA1) then stated one brief is in the trash and the other is still on resident. I went to investigate further and noted soaked briefs with urine and BM. Supervisor notified. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 125007	Facility ID: 125007 If continuation sheet Page 1 of 4

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Email from CNA2 to Administrator dated 2/24/23 at 10:46 PM: The email described in detail the activity on CNA2's shift, and included . I answered 5 lights or alarms by the time i [sic] made it to my group and then had a resident in bed to change her because she had a BM, the next shift was coming on and I told her (CNA1) i needed to change 115B. I went to put the lift (Hoyer) back and was asked for help, and forgot to go back. (to change the brief) . 3) Reviewed the facility policy titled Incontinence Care, last effective date 06/19/2023. The purpose included: To keep skin clean, dry, free of irritation and odor, To identify skin problems as soon as possible so treatment can be started, To prevent skin breakdown, and to prevent infection. 4) Reviewed R1's CP, which included the problem I have dementia and Hx (history of) CVA (Stroke) with hemiplegia and because of this my toileting ability fluctuates. I fluctuate from frequently to always incontinent of bladder. The short term goal was Risks for complications r/t (related to) incontinence such as MAISD (MASD-moisture associated skin damage), PU (pressure ulcer), loss of dignify, and UTIs (urinary tract infections) will be minimized daily. The approach included: I require extensive to total assistance for toileting. I am dependent for toileting hygiene and toilet transfer. Offer me toileting, and check for incontinence during rounds and as needed. Reviewed R1's annual MDS (minimum data set) assessment dated [DATE], which documented in section H-Bowel Bladder, R1 was always incontinent. Reviewed R1's Vitals Report, where CNA's document brief changes. The report revealed on 02/24/2024, CNA3 documented brief change with medium amount of urine at 07:09 AM, and medium amount of bowel movement at 07:10 AM. CNA2 recorded large amount of urine at 09:48 AM. The next documented brief change was by CNA1 at 08:42 PM, which was a large amount of BM and urine. 5) Reviewed R2's CP, which included the problem that: I am at risk for UTI, as I am incontinent of bladder and bowel and I have a history of UTI. The approach included Keep me dry and free of fecal material every round. Clean thoroughly after each elimination . Promptly change soiled undergarments. The CP also included I am at risk for skin breakdown i.e. ulcers, rashes, skin tears, uro-fecal irritation and /or MASD r/t incontinence of bowel and bladder The approach included .-Provide prompt incontinence care and apply barrier cream as needed. Reviewed R2's Vitals Report which documented brief changes on 02/24/2024. CNA3 documented pad/brief changed with large amount of urine at 07:09 AM. The next brief change was documented by CNA1 at 08:24 PM, also noted to be large amount of urine. There was no documentation of a brief change by CNA2 during her shift. Reviewed R2's MDS assessment dated [DATE], which documented in section H-Bowel Bladder, R2 was always incontinent. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6) On 04/11/2024 at 01:00 PM during an interview with CNA2, she stated she was a Traveler at this facility for about four months and worked day shift. She said the routine is to do a walk through together with the previous shift CNA and check residents at about 06:45 AM. At this time, we make sure the residents are not wet. She explained sometimes residents don't want to be disturbed at night and want to sleep. CNA2 went on to say after that we get up them up for breakfast, pass trays, set up, and feed anyone that needs assistance. After breakfast, collect trays and then do rounds. She said they round every 2 hours and she physically puts hands on to touch to see if wet or dry. CNA2 said that day (02/24/2023) was busy, but it was not a staffing issue. She said she recalled doing her second round and was trying to get to the end of the hall, and remembered telling the oncoming CNA1, she still needed to change one resident, and the other had family in the room all afternoon. She said when she got home, she realized she forgot to change one of the residents. CNA said after that day, Administration spoke with her and she was required to complete additional education prior to coming back to work. On 04/11/24 at 01:30 PM, during an interview with CNA1, she said she was a Traveler at this facility for almost 3 months. She said she found 115B (R1) not changed and bed pad wet. She said the brief was flooded, and immediately changed it and then notified the Nurse (LN)1. CNA1 said LV1 wanted to see the brief, so she took her to the garbage can and showed it to her. She said the staff do rounds and check if residents need to be changed every two hours. CNA1 said in orientation they stressed the importance of rounding every two hours and providing incontinence care if needed. On 04/11/2024 at 01:45 PM, during an interview with LN1, she said that day (02/24/2024), CNA1 notified her she didn't think the day shift CNA changed 115B (R1) because her brief was soaked and also was going to change 114B, because her briefs were also soaked. LN1 said she wanted to confirm what CNA1 said, so requested to see the briefs. She saw the brief in the trash for 115B (R1), and said they were soaked briefs with urine and BM. LN1 said she and CNA1 then went together to the next room (114B/R2) and she confirmed R2's brief was also soaked. LN1 said I've seen heavy wetter's, but this wasn't just that. She said neither resident was cognizant enough to be able to communicate if they were wet. On 04/12/2024 at 10:30 AM, during an interview with the Director of Nursing (DON), he confirmed it was the expectation CNA's round and check for the need to change briefs every two hours. He said all staff receive training on incontinence care in orientation and ongoing. The DON went on to say as soon as LN1 notified the supervisor, the investigation started. He said the investigation included interviews with residents and staff to identify if any other issues with incontinence care or quality issues with the care CNA2 provided. All residents were immediately rounded on, and skin checks completed and documented. There were no issues of skin integrity found or any other issue. 7) On 04/12/2024 at 09:00 AM, observed R1 up in a wheelchair outside her room. She appeared well groomed and comfortable. R1 was not interviewable. On 04/12/2024 at 09:08 AM, observed R2 lying in bed. She was well groomed, and answered simple yes, no questions. R1 has a communication deficit due to her dementia and cognitive impairment related to intracranial hemorrhage, so unable to conduct a full interview. R1 was noted to have a recent documented brief change. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8) In summary, on 02/24/2024, a staff member identified two residents she felt did not receive the quality of incontinence care they needed and immediately reported the issue. The LN notified the supervisor, who contacted administration and the investigation was started. CNA2 was suspended pending investigation, Adult Protective Services and OHCA were notified. The facility completed a thorough, timely investigation, which included resident and staff interviews, and skin assessments on all residents in the neighborhood. CNA2 was counseled and received additional training, which was confirmed. The resident sample was expanded to include five additional incontinent residents. RR revealed documented brief changes and no skin integrity issues. The deficient quality of care practice had been identified, and addressed. There was no deficient practice identified at the time of the survey. This deficient practice met the criteria for past noncompliance.		