

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 08/12/2024
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.			
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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. 43245 Based on interview and record review, the facility failed to honor the right of Resident (R)3 to receive visitors of her choosing at the time of her choosing, for both visits and telephone calls. As a result of this deficient practice, R3 was denied the opportunity to speak with her son when he called on the phone and denied the choice of receiving visits from her husband. This placed R3 at risk for a decline in her quality of life and prevented her from attaining her highest practicable well-being. The facility corrected the deficient practice prior to the abbreviated survey to investigate a complaint filed on her behalf. Findings include: On 07/29/2024, the State Agency (SA) received a complaint forwarded from the Long-Term Care Ombudsman (LTCO) and a complaint from the attorney of Resident (R)3's family member (FM)1, both detailing how the facility had denied visits/access to R3 from all family members except for her power-of-attorney (POA), as well as the LTCO. On 08/05/24, the state agency received an e-mailed complaint from FM1 detailing several concerns about her care. Among them was the following: On June 17, 2024, I phoned . [the facility] and requested to speak to my mother . I stated my full name to the nurse . and he told me I cannot speak to my mother and I needed permission. Assuming this was a mistake I called the following day. The nurse said I am denied from calling my mother and wasn't allowed to visit her as well . My stepfather . called me saying he was denied visits and speaking to his wife. Review of the facility's Visitation Policy, last updated 10/01/22, revealed the following: [Facility] . provides 24-hour access to all individuals visiting with the consent of the resident/guest. Review of the facility's Resident Rights policy and procedure, last revised 05/01/22, revealed the following: The resident has the right and this facility promotes and support [sic] the right to make choices about aspects of his/her life in the facility . including . Receive visitors at a time the resident chooses. (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: Facility ID: 125007
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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's progress notes in her electronic health record (EHR) noted the following: 06/17/2024 02:19 PM Nurse Progress Note, Received report from unit clerk that . [FM1] . called the unit and was trying to get hold of resident however unit clerk is aware of POA's order not to give the phone to resident. 06/19/2024 10:31 AM Nurse Progress Note, . [FM1] called unit again yesterday. Charge Nurse informed him that POA asked us to not accept phone calls without her consent. 07/04/2024 08:48 PM Nurse Progress Note, . received call from POA . upset that phone call protocol for the resident was not observed. POA reassured that Phone call protocol for the resident is known by staff and note is on the report paper . Nurse [Nurse 4] . made aware of the Phone call restriction for the resident . 07/08/2024 11:25 AM Administrator Progress Note, . POA phoned with concerns that a nurse did not screen her call the night before. Administrator apologized and did provide education to staff on unit regarding NO INFO and NO VISITORS without POA approval. On 08/09/2024 at 11:49 AM, an interview was done with Unit Manger (UM)3 at the Unit 3's Nurses' Station. UM3 confirmed that prior to the end of July, the unit had a strict protocol they followed whenever a visitor other than R3's POA tried to contact her. Per the POA's wishes, all visitors (including phone calls) had to be screened and approved by the POA. Asked for a copy of the report paper listing the protocol. UM3 reported she no longer had a copy as it had been destroyed when the protocol changed, but it used to be kept in the communication/schedule binder. UM3 stated that since the end of July, when visitors call for R3, the facility now asks who is calling and transfers the call to R3. UM3 also confirmed that R3 can now receive visitors other than her POA, reporting that R3 was visited by her son and husband at the end of July. Further review of R3's progress notes revealed the following: 07/23/2024 12:49 PM Administrator Progress Note, POA . was phoned yesterday updating him [sic] that . POA documentation does not allow for her to limit visits . due to that, brother will visit this week . 07/24/2024 11:20 PM Nurse Progress Note, Family/son at bedside during dinner. Confirmed w/ [with] administrator . regarding visitors and [Administrator] stated, anyone can visit resident. Res [Resident] happy and in good spirits.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interviews, document and record review (RR), the facility failed to ensure that two Resident's (R)1 and R2 of a sample of four had their comprehensive care plans (CP) reviewed and revised in a timely manner to include high risk behaviors that needed to be closely monitored. R1 had exit seeking behavior, which was not added to the CP in a timely manner, and R2 was not swallowing his medications at the time of administration, which was not added to the CP. As a result of this deficient practice, there was increased risk the behavior would reoccur and may result in a negative outcome. This deficient practice has a potential to affect all residents. Findings include: 1) R1 is [AGE] year old male admitted to the facility on [DATE] after being hospitalized for delirium tremors, alcohol withdrawal, chronic alcoholism and lactic acidosis (build-up of lactic acid in bloodstream). He lived alone and completely independent prior to his admission. His medical history includes severe alcohol use disorder, alcoholic cirrhosis, and pancreatitis. On arrival to the facility, he was alert and oriented x2 with intermittent confusion. His admission assessment for risk of elopement revealed he was no risk at that time. RR of R1's progress notes revealed the following entry: 07/21/2024 at 02:16 PM, Nursing progress note: At 1315 (01:15 PM) resident was observed by East staff propelling his wheelchair exiting East exit door. East staff notified the unit. Went to check resident, observed resident left wheelchair on East gate, observed walking out the building with unsteady gait. Per resident he wants to go home. He doesn't want to [sic] his medications because it makes him loopy. Resident re-oriented .he is here for therapy to get stronger for him to go home safe. Made aware that resident have rights to refuse his medications; that if he wants to leave the facility, he will be AMA (against medical advice), . Resident brought back to unit via wheelchair. Wanderguard (wander alert system) initiated. Notified Administrator, .Therapeutic communication done. Encouraged to wait until tomorrow to get his wallet, talk to social worker and the doctor before he decides to leave AMA. Resident calmed down.Will continue to monitor. 07/22/2024 at 10:30 AM, at 03:17 PM Social Service note: .SSA (Social Service Assistant) discussed exit seeking/intent to leave facility. Resident stated, I don't wanna leave. I like everybody here. SSA discussed DC (discharge) plan. Resident agreeable to remain in facility to complete skilled therapies, . RR of R1's CP revealed the following entries: On 07/23/2024 the SSA revised the CP to include: Approach: EXIT SEEKING: Ask me if I need anything, or offer me drink/food/toilet/lie down/activity - monitor my whereabouts . - Follow me for safety until I can be redirected. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/2024 Registered Nurse (RN)1 revised the CP to include the Problem: I am at risk for elopement as I have exit seeking behavior, propel myself in my w/c (wheelchair) or walk on my own and may go outside the facility. The Approach included: Please check on me hourly due to elopement episode. Monitor me for agitation, restlessness, change in behavior and attempts of trying to get out of the facility. R1 first had exit seeking behavior on 07/21/2024. The CP was not revised until 07/23/2023. On 08/12/24 at 10:15 AM, during an interview with SSA1, she confirmed R1 first had exit seeking behavior on a weekend (07/21/2024), and she met with him when she became aware of the incident. She said at that time, R1 said he had no intent to leave the facility. She confirmed she added to his CP on 07/23/2024. On 08/12/2024 at 10:30 AM, interviewed Registered Nurse (RN)1. He said the first time he was assigned to R1, the night shift reported him to be confused, and he didn't know why he was here, and wanted to go home. RN1 said he would reorient R1. He said he was able to walk by himself, but wobbly and not stable. RN1 said on 07/21/2024, One of the staff from East saw R1 trying to go out. He was in front of East, outside the building, and was walking. The w/c was left near the gait. RN1 said he reoriented R1 again, and explained his rights. He said he told him he was not safe to leave and may get injured. RN1 further explained R1's friend was called who also reinforced the need to stay at the facility. RN1 said he applied a WanderGuard, but did not complete an incident report, or revise the CP. On 08/12/2024 at 11:45 AM, interviewed RN2. She said she needed to update another residents CP because of exit seeking behavior and knew R1 had tried to leave, so she looked at his CP as a sample to develop hers for the other resident, but did not see anything regarding the exit seeking behavior, so she added something on 07/25/2024. 2) R2 is a [AGE] year old male admitted to the facility on 06//07/2024 from the hospital. His medical history included. but not limited to hypertension, chronic obstructive pulmonary disease, chronic severe alcohol use disorder, moderate opioid (pain medication) use disorder, nicotine dependence, cluster headaches and chronic pain. Prior to hospitalization he was homeless and had been a victim of assault. R2 is alert and cognitively intact. His primary mode of transportation is wheelchair. RR of R2's progress notes revealed the following entries: 07/03/2024 at 02:22 PM: . Approximately around 09:30 AM, CNA (Certified Nurse Assistant) reported to this LN (licensed nurse) that she saw the resident drop a white, round pill on the floor and the resident asked for it back. Resident received the pill at that time and put it in his shirt pocket. The resident told this LN he put the medication in his mouth when he went outside and stated it was his Dilaudid (pain medication). This LN educated the resident regarding correct medication administration time, resident appeared frustrated, but expressed understanding. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/07/2024 at 11:36 AM: NOC (night) LN notified this LN that a cup with a tab (Tablet/pill) of dilaudid was found in his (R2's) room. Per LN resident had reported that he was not woken to take the med but was informed that pill would only have been given upon request, as it is not scheduled. Noted that LN's have previously been instructed to watch resident take medications to ensure resident does not drop med, or hide/hold it for later. LN reported that resident appeared unhappy with having her witness med administration . 07/22/2024 at 10:22 PM: .At 8pm when giving resident his medications he asked which pain med, this nurse pointed out morphine, resident then put the pill in his mouth and drank water. Resident then observed taking a white pill out from the side of his upper cheek near the gum line and self propelling wheelchair away, this nurse then asked resident if he wanted the medication and educated that he was allowed to decline any meds. Resident stated I was going to take it later. Nurse then educated resident could take med or decline but that he may not store any meds in his room especially since its a narcotic . 07/23/2024 at 07:35 AM: .Resident was given PRN (as needed) Dilaudid 4 mg (milligrams) at approximately 05:40 a.m. for c/o (complaint of) pain all over. Medication given with routine early morning medications, observed resident swallowing meds and had resident show this LN that meds were taken and not being held in his gum line or under his tongue r/t (related to) resident holding pain medication in his mouth and then crushing on the night stand and then rubbing powder medication onto his gums, per resident it gets into bloodstream faster. 07/29/2024 at 03:25 PM: Resident received routine pain meds in AM shift. Found out resident still stuck morphine in mouth and also kept it in hand. 08/01/2024 at 08:44 AM: . Resident continues to pocket pain medication into gum on left side of mouth. Resident asked to please swallow medication and nurses to verify resident not packing medication. Resident will crush and rub on gums or inhale it. Resident given education on possible side effects but states I've been doing this for a long time now, it won't hurt me. RR of R2's active CP revealed the nursing staff did not revise the R2's CP to include the behavior of pocketing his medication or not swallowing them at the time of administration. On 08/09/2024 at 12:23 PM, during an interview with the Unit (Pikake) Manager (UM)1, she said R2 was alert and oriented and very manipulative. She said when nurses administer medication, they are suppose to stay with the resident and make sure the medication is swallowed. UM1 went on to say one of the nurses reported to her that she noticed R2 trying to hide the pills in his teeth or under his tongue. She said the nurse explained to him he had the right to refuse the medication if he did not want to take it, but he has as chronic pain, so the reason for pocketing was not that he did not want the medication. UM1 said R2 needs a lot of reminders about taking medications, and that from what she knew, he had been trying to the pills to take later. UM1 said there was one time a pill was found on the floor by a CNA, who notified the nurse, and another time when someone walked in when he was crushing a pill. At that time the medical record was reviewed and UM1 confirmed this high risk behavior had not been added to the R2's CP.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to provide the necessary care and services to maintain the activities of daily living, including personal hygiene for one of three residents sampled. As a result of this deficient practice, Resident (R)3 was hindered from attaining her highest practicable well-being. This deficient practice has the potential to affect all residents at the facility. Findings include: Resident (R)3 is an [AGE] year-old female admitted to the facility on [DATE] for long-term care. Her diagnoses include, but are not limited to, a history of cerebral infarction (stroke), chronic kidney disease, diabetes with diabetic peripheral angiopathy without gangrene (changes in blood vessels that contribute to the formation of plaques in the arteries of the limbs, particularly the feet and legs), and other nail disorders. On 08/05/2024, the state agency received an e-mailed complaint from R3's family member (FM)1 detailing how when he had visited R3 from July 24 to July 28, he had made several observations that were concerning to him regarding her care. Among them was the following: My mother has not been given a bath I smell her hair and scalp and it doesn't smell like she has been showered at all. On 08/09/24 at 11:30 AM, observation was made of R3 seated in her wheelchair outside in the breezeway of Unit 3. Although her hair appeared combed, there was a slight odor emanating from her. She did not smell of urine or feces, more of a body odor. A review of R3's Comprehensive Care Plan (CCP) for Activities of Daily Living (ADLs) noted the following intervention for bathing: I prefer having a shower . If I refuse, reapproach me at a later time. If I continue to refuse, call my daughter and have her speak to me about taking showers in that case I am most likely compliant after I speak to my daughter. A review of R3's point-of-care history for bathing for the month of July 2024 noted a pattern of one shower documented per week, every Sunday (except for 07/08/2024 where an extra shower is documented). In addition, there is documentation for 3 out of 5 Wednesdays in July where R3 was offered a shower and refused. No documentation that a shower had been offered at another time. A review of her progress notes revealed no documentation that her daughter was called. The review confirmed that R3's last shower prior to FM1's visit period was 07/21/2024, and she was not showered again until he departed on 07/28/2024. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/09/2024 at 11:40 AM, an interview was done with Lead Certified Nurse Aide (CNA)8 in the Unit 3 breezeway. Per CNA8, showers/baths are done twice a week for all residents. R3 is on the schedule for Sundays and Wednesday evenings. CNA8 stated that if any resident refuses to shower, they should be approached and offered a shower at another time because sometimes they just don't want to get up. CNA8 confirmed that any time a shower is offered or refused, it should be documented in the point-of-care system. On 08/09/2024 at 11:49 AM, an interview was done with Unit Manager (UM)3 at the Unit 3 Nurses' Station. UM3 confirmed that residents should be bathed/showered at least twice a week. If a shower is refused, she would expect it to be offered again. During a concurrent review of R3's point-of-care history for bathing for the month of July 2024, UM3 agreed that R3 should be offered and receiving more than one shower per week. While UM3 stated that R3 is frequently non-compliant with care, she acknowledged that the showers should still be offered as scheduled, consistently documented, and if refused, there should be documentation that it was offered again at a later time. UM3 agreed no resident should go a week or longer without a shower. Further review of R3's point-of-care history for bathing for the months of May, June, and August (up until the survey date of 08/09/24) 2024 revealed the following: May - Showers documented on 05/01/2024, 05/03/2024, and 05/05/2024, one documentation of Not Attempted Medical/Safety Concerns on 05/13/2024, then nothing until a shower on 05/29/2024. No documentation that a shower was offered and refused for the entire month. Leaving a summary of four showers in May with a maximum of 23 consecutive days without a shower. June - Showers documented on 06/02/2024, 06/09/2024, 06/12/2024, 06/16/2024, 06/22/2024, and 06/30/2024. Refusals documented once each on 06/23/2024 and 06/26/2024. Leaving a summary of six showers in June with a maximum of seven consecutive days without a shower. August (1st through 9th) - One shower on 08/07/2024 with the last shower documented prior to that on 07/28/2024. No refusals documented in August. Leaving a maximum of nine consecutive days without a shower.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to provide adequate diabetic foot care for Resident (R)3. As a result of this deficient practice, the facility placed R3 at risk for avoidable injuries. This deficient practice has the potential to affect all residents in need of diabetic foot care. Findings include: Resident (R)3 is an [AGE] year-old female admitted to the facility on [DATE] for long-term care. Her diagnoses include, but are not limited to, a history of cerebral infarction (stroke), chronic kidney disease, diabetes with diabetic peripheral angiopathy without gangrene (changes in blood vessels that contribute to the formation of plaques in the arteries of the limbs, particularly the feet and legs), and other nail disorders. On 08/05/2024, the state agency received an e-mailed complaint from R3's family member (FM)1 detailing how when he had visited R3 from July 24, 2024 to July 28, 2024 he had made several observations that were concerning to him regarding her care. Among them was the following: Her big toe nail [sic] on both feet are overgrown about 3/4 [inch] on the right foot while the left foot is 1 inch. Review of R3's electronic health record (EHR) noted that she has been seeing a DPM (Doctor of Podiatric Medicine) since 12/17/2021. Review of each of her DPM consultations revealed the following: 12/17/2021 - Patient has had lower limb and toenail problems on both feet with symptoms of pain and discomfort. Patient is incapable of trimming own nails safely and have [sic] multiple medial [sic] conditions that require professional palliative care . Manually and with electric grinder debrided the affected nail plates digits 1-5 bilaterally [on both sides] . recommend follow up appointment with our office in 2 month(s) . No DPM follow up documented until almost a year later on 11/08/2022. 11/08/2022 - Nail Pathology: pain on palpation . thick . elongated . Dystrophic (general term for tissue degeneration) nails . Hammer toes (A foot condition in which the toe has an abnormal bend in the middle joint) - diffuse (spread out) reducible contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of lesser digits (toes) . 05/11/2023 - Trimmed all dystrophic toenails on both fet [sic] that are dystrophic, brittle, gryphotc (thickening and increased curvature of the nail plate), thickened, discolored, elongated and/or incurvated (curved inward) . F/U (follow up) 61 days. R3 was also seen by the DPM on 07/24/2023 and 11/22/2023, which no changes from above noted. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Despite being followed by a DPM, a review of R3's Comprehensive Care Plan revealed no interventions for foot/toenail monitoring or care. On 08/09/2024 at 12:56 PM, an interview was done with Unit Manager (UM)3 at the Unit 3 Nurses' Station. When asked about the process of diabetic foot care and toe nail care for R3, UM3 stated that facility nurses could cut her toe nails as needed. When questioned about whether that was appropriate given R3's history of toe and toenail pain, problems, and deformities, and her history of DPM consults for nail care, UM3 responded that R3 had a history of non-compliance with consultations but that nursing could make a referral to podiatry as needed. When asked if a referral was needed given her last podiatry visit was in November of last year, UM3 reported that she was not aware that it was necessary yet. UM3 stated that the expectation is that all residents' feet and toenails should be assessed at least weekly with the weekly skin assessment. When asked where staff would document that the toenail assessment had been done, UM3 responded that it would only be documented on the weekly skin assessment form if a problem was noted. A concurrent review of the weekly skin assessments for the last month (07/12/2024, 07/19/2024, 07/26/2024, 08/02/2024) confirmed no documentation found of a problem with R3's toenails. State Agency (SA) asked UM3 to do a quick assessment at this time. On 08/09/2024 at 01:02 PM, observations were done with UM3 of R3's right foot and toenails as she sat in her wheelchair eating lunch. Both feet were covered with soft, formed booties. Assessment of R3's left foot was deferred as to not interrupt her lunch too much or cause her distress. After obtaining R3's consent to take a quick look at her right foot, UM3 removed the bootie to reveal dry skin to the foot itself, with all toenails elongated and curved. The toenail of R3's great (big) toe was approximately 2.5 centimeters long. When asked if she could verbally describe what she saw for the SA, UM3 responded the nails are long, and her skin is dry. UM3 agreed that the great toenail in particular was of a length that it posed a potential for injury. After repeated questioning, UM3 reluctantly agreed that as the UM, she would expect to see toenails addressed prior to the point where they are a safety concern. UM3 could not explain why there was no documentation on the weekly skin assessments of R3's current foot/toenail status. On 08/12/2024 at 04:09 PM, a phone interview was done with the Director of Nursing (DON). When asked about diabetic foot/toenail care for R3, DON stated that usually when the nurse does their weekly skin assessment, if they take notice that her nails are problematic, then they should make the physician aware, and the physician decides if she needs a DPM referral. DON confirmed that in the case of R3, because of her history, the nurses should not be cutting her toenails without referring it to the physician (or nurse practitioner) first.		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interviews, document and record review, the facility failed to provide the appropriate supervision and put interventions in place to prevent one Resident (R)1 with moderate cognitive impairment from elopement, resulting in harm. Although R1 exhibited exit seeking behavior on [DATE], he was able to leave the premises in his truck on [DATE]. R1 got lost and was returned to the facility approximately five and a half hours later by the local police department. As a result of the elopement, R1 suffered psychological and physical harm. R1 was afraid when police found him. When returned to the facility, he was cold, and both feet were swollen. In addition, the facility did not follow their own elopement risk program which endangered R1's health and/or safety as well as putting the public at serious risk when R1 drove a vehicle. Findings include: 1) On 07 ,d+[DATE], the Office of Healthcare Assurance (OHCA) received a Facility Reported Incident (FRI), #11099 that included the following: R1 is a [AGE] year old male patient admitted on [DATE] with primary diagnosis of alcohol induced acute pancreatitis, alcoholic cirrhosis of the liver, alcohol dependence with withdrawal delirium and anemia. The patient is his own responsible party and has no family contact available. His emergency contact is a friend. The patient has mild to moderate cognitive impairment as evidenced by a BIMS (brief interview for mental status) of ,d+[DATE]. (BIMS score ,d+[DATE] indicate severe cognitive impairment, scores between 8 and 12, moderate impairment while scores above 13 show little to no impairment). On [DATE], at 1248, the LN (licensed nurse) made rounds and noted the resident was gone. At 1349 (01:49), R1's emergency contact/friend called the facility and reported R1 had contacted her to let her know where he was. The emergency contact called the police who were in active search for him. R1 was found to have gotten in his vehicle and drove to Wailuku where his car battery allegedly died . The police left the car in place and brought him back to the facility at 1820 (06:20 PM). 2) Review of Progress Notes revealed the following: [DATE] 03:15 PM, Nursing note .Alert x,d+[DATE], . no acute pain reported.Bipedal edema noted. [DATE] 02:16 PM, Nursing progress note: At 1315 (01:15 PM) resident was observed by East staff propelling his wheelchair exiting East exit door. East staff notified the unit. Went to check resident, observed resident left wheelchair on East gate, observed walking out the building with unsteady gait. Per resident he wants to go home. He doesn't want to [sic] his medications because it makes him loopy. Resident re-oriented .he is here for therapy to get stronger for him to go home safe. Made aware that resident have rights to refuse his medications; that if he wants to leave the facility, he will be AMA (against medical advice), Resident brought back to unit via wheelchair. Wanderguard (wander alert system) initiated. Notified Administrator, .Therapeutic communication done. Encouraged to wait until tomorrow to get his wallet, talked [sic] to social worker and the doctor before he decides to leave AMA. Resident calmed down.Will continue to monitor. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	[DATE] 03:27 PM, Nursing note: .Resident with restlessness.Triggered alarm several times. Very impulsive. Resident observed walking on own with unsteady gait. Difficult to redirect. He is able to propel self around the unit. Close supervision required. [DATE] 04:17 PM, Nursing note: BLE (bilateral lower leg) pitting edema (type of swelling that leaves an indentation when pressed on the skin) . [DATE] 00:27 AM, Nursing note: Self reported fall/pain .observed ambulating inside his room, and unit hall with no assistive device. Remind res (R1) that he is not cleared yet to ambulate by himself. Res continues to ambulate by himself. S/P (after) fall (self reported) res complaints of pain to R (right) knee due to fall per res, also his usual pain to shoulders, feet, and abdomen going up to his upper body.edema to bilateral feet. [DATE] 06:28 AM, Physician order: ACE wrap to bilateral feet and calves while up daily. [DATE] 09:11 AM, Dietary Progress note: . Previously noted with pitting edema to BLE, currently noted with no edema to BLE per MD. [DATE] 02:40 PM, Social Services note: Social Service Assistant (SSA)1 observed to be in East Unit talking to LN (licensed nurse). He (R1) was holding a map. SSA intervened and approached resident in a gentle manner and asked if he needed assistance. Resident stated that he was looking for the parking lot as he was worried that his truck will be towed. SSA assured him that Admin (Administrator) is aware of his parked truck on premises and that Admin approved. He was relieved and grateful. No concerns noted. Resident returned to [NAME] unit with no issues. [DATE] 03:47 PM, Nursing note: . Res (R1) redirected often as he is ambulating with no device around his room and unit, encouraged to use wheelchair for safety. Res continues working with therapies and needs supervision as he is weak and unsteady at times. some mild confusion at times but able to be re-directed. [DATE] 04:49 PM, Nursing Note: .At 1220 this RN noticed that the resident was not in his room and began to search . [DATE] 09:41 PM, Nursing Note: resident returned from elopement 1820 (06:20 PM), resident c/o (complained of) being cold and shaking slightly.Resident c/o pain in feet, both feet swollen d/t (due to) walking around.Car keys, phone and wallet obtained by supervisor. 1830 (06:30 PM) c/o ,d+[DATE] pain to entire body, given prn (as needed) narco (for pain) with some effect. 2000 (08:00 PM) Prn (as needed) melatonin (for sleep) given with no effect, resident remains restless and wandering around unit, . [DATE] 05:06 PM, Nursing note: .Continues with pitting edema + 1 to BLE, on ace wrap order, encouraged BLE elevation when in bed. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	[DATE] 10:58 PM, Nursing note: 1820 (06:20 PM) - Resident stated he just wanted to go to the Ka'ahummanu mall to look for an iPad for his son but got lost coming back. He stated he did not let the staff know because he thought he will only take ,d+[DATE] mins (minutes). Stated that his battery went off. He tried to come back but and went all the way to Walgreens Wailuku. He went to Walgreen to charge his phone and was able to contact friend and she updated MPD (Maui Police Department). Per MPD, they found him near the Trampoline Park (approximately two miles from facility) in Wailuku and left his car. Friend came in for visit, spoke with resident and car key given. Per friend, she will keep his car for now. Elopement risk completed. Resident educated on Elopement and OOP (off of premise) procedures. Stated understanding and will let staff know when he wants to go .No other concerns at this time. Placed on hourly monitoring s/p elopement. Wander guard in place. [DATE] 04:47 PM, Nursing note: Continues with pitting edema + 1 to BLE, on ace wrap order, encouraged BLE elevation when in bed. 3) Reviewed the facility policy titled Elopement Risk Program effective date [DATE]. The policy included the following: 1. Utilizing the Elopement Risk Evaluation-evaluate the resident for exit seeking risk on admission/quarterly/with significant change of condition. a. If resident is a risk for elopement: I. Facilities with wanderguard (or similar system): If the resident is evaluated at risk for elopement/wandering, obtain a physician's order for a wanderguard and to check function each day.II. When a resident is determined to be an elopement/wandering risk, staff need to account for the resident's location every two hours. III. For the resident identified as a risk for elopement/wandering complete the Missing Resident Profile with the resident's picture, and place it in a binder kept at the nursing stations and receptionist desk. IV. Initiate the Behavior Monitoring form with the behavior wandering or exit seeking to monitor the resident's wandering behavior. V. Care plan behaviors, specific prevention interventions and obtain physician orders as necessary. (a) Communicate the elopement/wandering prevention interventions to staff. (b) Make sure the risk for wandering/elopement is on the resident's care plan. The facility did not conduct another elopement risk evaluation after his exit seeking behavior on [DATE]. Although the RN put a WanderGuard on at that time, the RN did not obtain the MD order, or revise the Care Plan or implement frequent monitoring for the exit seeking behavior. RR revealed the first Elopement Risk Assessment was completed on admission [DATE], at which time R1 showed no evidence of risk for elopement. The next Elopement Risk Assessment was completed [DATE] at 07:10 PM, after R1 eloped and was returned to the facility by the police. 4) On [DATE] at 10:15 AM, conducted an interview with Social Service Assistant (SSA)1 in the conference room. She said she saw R1 looking at a facility map on [DATE], and inquired what he was doing. R1 told her that he was trying to look for a parking space, as administration had made an exception to policy, and was going to allow him to keep his car on the premises. SSA1 acknowledged she was aware of his exit seeking behavior at that time. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] 10:30 AM, conducted an interview with Registered Nurse (RN)1, who cared for R1 on [DATE], when he first displayed exit seeking behavior. RN1 said after he located R1 and brought him back to the unit, he explained leaving the facility was a safety issue and he could get injured. At that time R1 placed a WanderGuard on R1, but did not do an incident report, did not revise the CP, and did not obtain an order for the WanderGuard, which would generate the task for the staff to monitor and document R1's whereabouts to ensure he was safe. RN1 also did not complete the Elopement Risk Evaluation per the facility Elopement Risk Program. On [DATE] at 11:06 AM interviewed the Director of Nursing (DON) on the telephone, who said when a resident displays new exit seeking behavior, a new Elopement Risk Evaluation should be done, and the RN should obtain an order for the WanderGuard. Staff would then monitor the residents whereabouts every two hours and document. In addition, the CNA (Certified Nurse Assistant) would check and document every shift the WanderGuard was on and functioning correctly. The DON said he was not aware that R1 had attempted to leave the facility on [DATE], and did not have details of the [DATE] elopement, such as how far R1 walked or drove, and that the Unit Manager (UM)2 had been assigned to investigate. He confirmed he did not do a root cause analysis or have documentation of an investigation. On [DATE] at 11:15 AM, interviewed UM2 in the conference room. She said when she was reviewing the [DATE] elopement, it was discovered there was no order for the WanderGuard, so a nursing order was entered at [DATE] at 11:45 AM, two days after the elopement. This order generates a notification to check the WanderGuard is on and operational every shift. When inquired if staff were educated on the process and knew if the WanderGuard order should be a nursing order or MD order, and what the specific monitoring expectations are, UM2 said they were putting a plan in place. She went on to say We are going to have a binder on the unit with Residents that have a WanderGuard. The facility policy stated there are binders on the units. Inquired what the missing Resident profile was that is suppose to be put in the binder, and she was not able to answer. Asked UM2 if she knew how far R1 had walked, she said He was coming down from Wailuku Walgreens, got lost coming down. Walked a couple miles. UM2 did not know specifics, or if he drove the car. She said His feet were sore and painful. UM2 later returned to the conference room to explain that the missing Resident profile would be a copy of the Resident's demographics in the medical record. On [DATE] at approximately 12:00 PM, interviewed the Administrator (ADM) in the conference room. Asked the ADM about follow up after the elopement and if a root cause analysis had been done. She asked if the DON had shared that information during his telephone interview, but informed her the DON said UM2 was doing the investigation. The ADM said she had not been aware R1 had previous exit seeking behaviors on [DATE], and acknowledged there had not been an incident report made for that event. She said when R1 eloped on [DATE] he took his truck and drove. She went on to say she had made an exception to policy, and allowed R1 to keep his truck on the premises, because he was so worried about it. Informed the DON the staff verbalized some discrepancies in policy regarding the WanderGuard order, and if it was a Nursing Order or Physician order. The ADM returned to the conference room shortly after the interview and provided a Google map of distance from Walgreens in Wailuku to where R1 was found by the police. The distance R1 is believed to have driven to Walgreens from the facility is approximately 2.6 miles. He got lost on the way back and found approximately .4 miles from the Walgreens. 5) Due to the high risk of this incident, there should have been a thorough investigation/root cause analysis conducted post elopement. The investigation was inadequate, undocumented and did not identify many of the issues that led up to the elopement on [DATE]. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	6) Review of the Police Department Case Summary Report last modified [DATE] revealed the police were notified by the facility R1 was missing about 01:25 PM, approximately one hour after they noticed he was missing. The report included: - he (R1) suffers from dementia and multiple other medical conditions and should not be out alone. - R1 notified his friend via telephone, and relayed he was lost and unable to get back to Hale Makua. On [DATE] at about 1730 (05:30 PM), contact was made with V,d+[DATE] (R1) near the intersection of [NAME] and Paa Street in Wailuku. V,d+[DATE] relayed he was lost, scared, and needed help getting back to Hale Makua, . 7) Cross Reference F657 Care Plan The facility failed to revise R1's care plan after his exit seeking behavior on [DATE]. The CP was not updated to include this high risk behaviors until [DATE].		