

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

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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 01/14/2025
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22063 Based on observation and interview with staff members, the facility did not execute a resident's right to reside in a clean home environment. Findings include: On 01/13/25 at 02:11 PM, observed Resident (R)1 in a wheelchair, self-propelling on her unit. At 02:17 PM, observed R1 enter room [ROOM NUMBER]. R1 transferred herself from the wheelchair onto Bed A and laid down. At 02:30 PM observed staff members enter room [ROOM NUMBER], stood by the foot of Bed A, then exit the room. At 02:35 AM, observed Certified Nurse Aide (CNA)1 enter room [ROOM NUMBER], close the privacy curtain and assisted R1 back to the wheelchair. CNA1 wheeled R1 back to her room. Observed room [ROOM NUMBER] with signage for Enhanced Barrier Precautions (EBP - set of infection control practices that involve wearing gowns and gloves during high-contact care for residents at risk of infection, i.e. indwelling medical devices, wounds). CNA2 reported the reason for EBP is R6 receives dialysis treatment. Observation from 02:40 PM to 02:50 PM, the linen for R6 was not changed. CNA1 was observed leaving the unit with personal belongings (bags). Interviewed Licensed Nurse (LN)1 at 02:50 PM. LN1 confirmed the linen needed to be changed and she would have someone change it. On 01/14/25 at 10:10 AM interviewed Infection Preventionist (IP) in the hall. Observation of R1 lying in R6's bed was shared with the IP. IP reported R1's lying in R6's bed may affect R6, however, it is basically a hygiene concern. IP further stated transmission of an infection is low.		

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	If continuation sheet Page 1 of 9

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 22063 Based on observations, record review, and interview with staff members, the facility failed to develop a person-centered comprehensive care plan for 1 (Resident 2) of 4 residents reviewed for wandering/elopement behavior. This deficient practice has the potential to place resident at risk for accidents (i.e., falls, resident to resident altercations) and affect the resident's ability to achieve and maintain her highest medical, mental, and psychosocial needs and to cause adverse effects related to falls and resident to resident altercations. Findings include: Cross Reference to F689. Resident (R)2 has been identified for being at risk for elopement with a history of wandering behavior. The facility failed to conduct annual and quarterly elopement risk assessments, and implement care plan for wandering behavior. On 01/13/25 from 12:00 PM to 01:00 PM intermittent observations found R2 wandering on her unit, sometimes stopping to talk to other residents and at times would follow staff around the unit. A review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/26/24 noted R2 was assessed with moderate cognitive impairment for decision making. R2 was also coded for wandering behavior which occurred one to three days in the observation period. On 01/14/25 at 11:07 AM, the Administrator reported they missed R2 in their audits. The Administrator also reported the facility does not have any documentation of an Elopement Risk Evaluation and confirmed a care plan for elopement risk was just developed on 01/13/25 upon discovery elopement risk evaluations for this resident was not done		

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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. 22063 Based on observations, record review, and interviews with staff members, the facility did not ensure a person-centered comprehensive care plan was reviewed and revised following an actual incident of elopement for 1 (Resident 1) of 4 residents in the sample. Findings include: Cross Reference to F689. Resident (R)1 had an actual elopement on 12/06/24 and wandering behavior that places R1 at risk for falls, resident to resident altercations, and elopement. Review of R1's quarterly Minimum Data Set (MDS) with assessment reference date (ARD) of 10/21/24 notes R1 yielded a score of 3 (severe cognitive impairment) when the Brief Interview for Mental Status was administered. R1 was also coded for wandering, occurring one to three days during the observation period. R1 requires supervision or touching assistance for walking 10 feet, walking 50 feet with two turns, and walking 150 feet. A review of R1's progress notes from 11/29/24 to 01/12/25 found entries of R1 wandering into other residents' rooms: 11/29/24 at 02:41 PM, R1 wandered into another resident's room at night; 12/08/24, R1 sometimes walked into other residents' room looking for the toilet; and 12/15/24 at 08:55 PM, R1 was wandering a lot on the unit and was found in another resident's room. Review of R1's care plan found approaches for wandering with a start date of 08/23/23. Approaches/Interventions included: ask me if I need anything or offer me drink/food/toilet/lie down/activity; monitor my whereabouts; provide redirection and reorientation as needed, state what I should do not what I should not do; follow me for safety until I can be redirected, I was issued a WanderGuard device that locks exit door when I approach. There were no care plan revisions to assess the efficacy of current approaches and/or to develop new approaches following actual event of elopement and incidents of resident entering other residents' rooms. On 01/14/25 at 07:50 AM an interview and concurrent record review was done with the Unit Nurse (UN). Inquired whether the facility revised R1's care plans after the wandering incident on 11/29/24. UN stated the team decided to place a Stop banner across the door of the room R1 entered. UN also stated it wouldn't be feasible to place these banners across all residents' doorways to prevent R1 from entering. UN was unable to confirm R1's care plan was revised.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 22063 Based on observations, record review, and interview with staff members, the facility failed to implemented residents' care plans to eliminate risk of an accident related to wandering and elopement and monitor the effectiveness of interventions as necessary for 3 of 4 (Residents 1, 2, and 3) residents sampled. 1) Resident (R)1 had an actual elopement, the facility failed to revise the resident's care plan to develop person centered interventions, direct care staff were unaware of approaches/interventions to employ for R1's wandering behavior and the wandering and exit seeking behaviors were not accurately monitored resulting in no baseline data to determine the efficacy of the interventions. 2) The facility failed to develop a care plan to prevent elopement for R2 with wandering behaviors prior to the start of the survey. The facility also did not implement or accurately document care plan approaches for monitoring the function of WanderGuard once a day and the targeted behaviors (wandering and refusal of medications). 3) The facility did not implement R3's care plan to assure an elopement assessment was done quarterly. The facility also did not recognize an elopement incident, resulting in no assessment of the incident and need for care plan revision. Findings include: 1) Cross Reference to F657. The facility failed to revise Resident (R)1's care plan following an incident of actual elopement and unsafe wandering (wandering into other residents' rooms). The facility submitted an Event Report on 12/06/24 at 08:30 PM regarding R1's elopement. On 12/06/24, R1 was found outside near fence in back of unit. R1's WanderGuard (a system that provides wander management for those at risk of elopement) bracelet reportedly was in place and functioning at the start of the shift. No alarms were heard. The final report was submitted on 12/10/24 at 02:35 PM. The facility clarified, R1 was found outside of the building behind the activities center. The House Supervisor saw the WanderGuard alert on another unit (North) and notified R1's unit (Pikake). Another staff member saw R1 from the window of another unit (Ilima) and notified the Pikake unit. The facility's investigation found the door to enter the activities department from the Pikake unit was not locked and R1 was able to enter the room and access the emergency exit door at the rear of the building. The emergency exit door is equipped with a locking mechanism that will allow the exit door to open after being held for 15 seconds. On 01/13/25 at 10:50 AM record review was done. R1 was readmitted to the facility on [DATE]. Diagnoses include but not limited to unspecified dementia, unspecified severity with anxiety; unspecified dementia, unspecified severity with agitation; nondisplaced intertrochanteric fracture of left femur (routine healing); cognitive communication deficit; aphasia (a language disorder that makes it difficult to understand or express language); and anxiety disorder. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 10/21/24 notes R1 has severe cognitive impairment and was coded for wandering behavior. R1 requires supervision or touching assistance for walking. A review of the Elopement Risk Evaluation dated 10/24/24 documents R1's risk score was 5 (high risk - further assessment is needed). Interventions recommended included elopement deterrent device implemented and elopement prevention care plan initiated or updated. Subsequent assessment dated [DATE] (following actual elopement), R1's risk score was 3 (moderate risk - improvement) with intervention recommended for elopement prevention care plan initiated or updated. Review of R1's care plan for behavioral symptoms with a start date of 11/09/22 identifies R1 has depression and agitation and may demonstrate the following challenging behaviors: agitation, restlessness, anxiety, wandering exit seeking behaviors, entering other resident's room, and refusal of care. An approach with start date of 08/23/23 was developed for wandering. Approaches include, ask me if I need anything or offer me drink/food/toilet/lie down/activity; monitor my whereabouts; provide redirection and reorientation as needed, state what I should do, not what I should not do; follow me for safety until I can be redirected; and I was issued a WanderGuard device that locks exit door when I approach. Other approaches include: being at risk for wandering/elopement due to cognitive impairment, refer to wandering care plan (start date 03/14/23); resident may express confusion and insist on going home, at these times, do frequent visual checks, as I may wander off unit, flow sheet for every hour (start date of 08/01/24); I use a Wander Guard, please check the placement every shift (start date of 06/23/23); and a falls care plan to monitor resident frequently for safety, encourage to take rest periods in between walking activity, when walking, I may become agitated when staff tells me that I require assistance, encourage me to use my walker and take breaks; and if I appear restless, increase rounding until I am calm. A review of the progress notes from 11/29/24 to 01/12/25 found documentation of R1 wandering into other residents' rooms: 11/29/24 at 02:41 PM, R1 wandered into another resident's room at night; 12/08/24 at 03:30 PM, R1 sometimes walks into other residents' rooms looking for the toilet; 12/15/24 at 08:55 PM, R1 was wandering a lot on the unit and it was reported R1 was found in another resident's room. The documentation in the progress notes were not detailed to identify which rooms R1 entered, what she was doing in the room, if other residents were present at that time, what interventions were tried to deter the behavior. There were other entries documenting R1 wandering on the unit, going from room to room and standing at the door, and exit seeking behavior. On 01/13/25 at 01:16 PM, observed R5 seated by the door of her room, R5 reported R1 was once found in her room, sitting on the toilet. R5 resides in room [ROOM NUMBER]. R5 reported being surprised to find R1 using her toilet. Upon discovery, R5 stated R1 shook her finger at her to indicate R5 was in the wrong. R5 also reported seeing R1 stand in front of other residents' doors, blocking their way into their room and walking about the unit. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/13/25 at 02:11 PM, observed R1 in a wheelchair, self-propelling on the unit. Did not observe staff members employing approaches for wandering. At 02:17 PM, observed R1 enter room [ROOM NUMBER]. R1 transferred herself from the wheelchair onto Bed A and laid down. At 02:30 PM observed two staff members enter the room, they stood by the foot of Bed A, then exited the room. At 02:35 PM, observed Certified Nurse Aide (CNA)1 enter room [ROOM NUMBER], the curtain was drawn closed while CNA1 assisted R1 back to the wheelchair. CNA1 wheeled R1 back to her room and assisted R1 back to bed. On 01/13/25 at 02:40 PM, interviewed CNA1. CNA1 confirmed R1 was in the wrong room. Inquired what are the approaches used to for R1's wandering. CNA1 reported the nurses know what to do. Further queried as an aide, what is she supposed to do, CNA1 responded she doesn't know what to do but the nurses know. CNA1 was asked how often is R1's whereabouts monitored, CNA1 responded one to two hours. On 01/14/25 at 07:50 AM interviewed the Unit Nurse (UN) at the Pikake unit in the nurses' station. Reviewed the progress notes with the UN. Inquired about incident of 11/29/24 when staff discovered R1 in a resident's room and the team decided to place a Stop banner in the doorway. UN initially could not recall the incident and later stated this entry documents R1 was found in room [ROOM NUMBER] and the team agreed to place a Stop banner on the door. Concurrent review of the progress notes documenting incidents of R1 wandering into other residents' rooms was done with UN. Requested UN review the care plan for revisions after the incidents. UN was unable to confirm R1's care plan approaches were revised to address wandering into other residents' rooms. Based on the progress notes, UN was unable to identify which rooms R1 wandered into and stated it isn't feasible to place Stop banners in all residents' doorways to prevent R1 from entering. Concurrent observation of room [ROOM NUMBER] was done with the UN. There was a banner affixed to the doorway which was not placed across the doorway. Inquired when does the facility use the banner, UN responded it is up to the resident. Further review of the Treatments Administration History (TAH) for December 2024 found a flow sheet for the approach to check WanderGuard placement every shift with instruction to use (+) present and (-) not. The flow sheet for December 2024 had entries documenting the WanderGuard was not present (-) for the following dates and shifts: 12/05/24 - NOC; 12/07/24 - PM; 12/09/24 - day; 12/12/24 - PM shift; 12/15/24 - PM; 12/16/24 - PM; 12/17/24 - day; 12/17/24 - PM; 12/23/24 - PM; 12/23/24 - NOC; 12/26/24 - day; 12/26/24 - PM; and 12/27/24 - NOC. There was also a flow sheet to monitor the following target behaviors: 1) agitation, 2) restlessness, 3) anxiety, 4) depression, 5) ambulate without assistance, 6) refuse care/treatment, and 7) poor appetite. Of the 63 opportunities to document for ambulating without assistance, there were only five entries to document R1 ambulated without assistance. This documentation was inconsistent with the progress note entries which noted 17 entries of wandering on unit (ambulating without assistance) and exit seeking behavior. Requested additional information on the morning of 01/14/25 to demonstrate the multidisciplinary team met to do root cause analysis and update R1's care plan. The facility provided a grievance report from R6 complaining that R1 has been wandering into her room every night and was awakened to find R1 staring at her. The team agreed to place a Stop banner across the R6's room and nursing staff was reeducated regarding wandering residents. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/14/25 at 11:07 AM interviewed the Administrator. The Administrator explained the staff reenacted the event and found that the WanderGuard triggered at the North unit, however, the alarm to the emergency exit could not be heard on the unit as the door was closed. The Administrator reported the team consulted the physician and assessed a possible causal factor was the drug interaction of Remeron (antidepressant) and Sertraline (antidepressant) may have contributed to increase in wandering behavior. R1's Sertraline dosage was decreased to 75 mg for seven days, then 50 mg after the first seven days. On 01/14/25 at 01:05 PM, discussed inconsistent documentation of wandering and elopement occurrences with the Administrator. Administrator reported the charting may be done according to who observes the behavior, the nurses or the aides. The Administrator provided documentation, Point of Care History for 11/14/24 to 12/14/24. There were six entries to indicate interventions were taken to alter wandering. Administrator reported the electronic record needs to be programmed for the aides to document wandering behavior. Inquired when was this behavior loaded to enable the aides to document this behavior. The Administrator was not sure. 2) Cross Reference to F686, Comprehensive Care Plan. The facility did not ensure R2's care plan was implemented consistently to monitor resident's targeted behavior of wandering every shift and ensuring the functioning of WanderGuard functioning once a day. Observation on 01/13/25 at noon saw R2 seated in a wheelchair in the hall next to the door of her room. Observation at 01:00 PM, R2 was standing at a table with two other female residents and talking. Subsequently, R2 was observed to follow staff around the unit. R2 was independently ambulatory. Later R2 was observed sitting at a table by the nurses' station, watching television. Later observed R2 seated in activities for volleyball, R2 was smiling. On 01/13/25 at 01:39 PM a record review was done for R2. R2 was admitted to the facility on [DATE]. Diagnoses include but not limited to, Alzheimer's with early onset; dementia in other diseases classified elsewhere, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety; chronic kidney disease, stage 2 (mild); wandering in diseases classified elsewhere; and other abnormalities of gait and mobility. A review of the quarterly MDS with an ARD of 11/26/24 noted R2 was assessed with moderate cognitive impairment for decision making skills. R2 was also coded for wandering behavior, occurred one to three days during the assessment period. The facility developed a care plan during the survey for R2 being at risk for elopement due to history of wandering and severe cognitive impairment. Approaches included: if I am going toward unit exit, please help me back to my room where staff can supervise me; I use a WanderGuard for safety, please check the placement every shift; if I become agitated and difficult to redirect, I may require 1:1 supervision to manage my wandering; and please refer to my activity care plan for my preferences and things that interest me. Prior approaches for wandering with a start date of 02/09/21 included but not limited to: 12/17/22 - WanderGuard to my dominant risk (right side) as I tend to wander around at night and attempt to leave the facility out of curiosity. Monitor my WanderGuard is in place every shift; and 12/27/22 - Wandering/exit seeking, when observed redirect me to my unit/room, offer me something to eat/drink or offer me to use the bathroom, encourage me to engage in group activities every shift (continued on next page)		

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