STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125007	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hale Makua - Kahului	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 0689 Level of Harm - Minimal harm or potential for 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** Based on observation, interviews, and record review, the facility failed to ensure adequate supervision and/or measures were in place to prevent accidents for one of one resident (Resident (R) 172) reviewed for elopement risk. As a result of this failure, R172 was able to elope from the facility without staff knowledge and arrived at a family member's home with assistance from another resident's visitor. Findings Include:R172 was admitted to the facility on [DATE] with diagnoses including, but not limited to, dementia, osteoarthritis of the right and left shoulders, spinal stenosis in lumbar region without neurogenic claudication, pain in the right and left feet, unsteadiness on feet, and a history of falls. Review of R172's quarterly Minimum Data Set (MDS), Assessment Reference Date (ARD) 09/12/25, revealed in Section GG (Functional Abilities and Goals) that the resident used a wheelchair for mobility and had impairment of one lower extremity. In Section E (Behavior), the resident was documented to wander, with the behavior occurring 1 to 3 days during the assessment period. No other behavioral symptoms were noted. Additionally, the MDS documented the wandering behavior as worse compared to prior assessments.Review of the initial facility reported incident (Intake #2687314), received on 12/06/25, documented on 12/06/25 at approximately 03:46 PM, R172 left the facility and went to a family member's house located in front of the facility with assistance. The incident report documented someone opened the door for her and took her to the house. Facility staff became aware of the incident when R172's son notified staff that the resident was at the family member's home.Review of a nursing note documented on 12/06/25, at approximately 03:56 PM staff were notified by resident's son that R172 was in their driveway. The notes further documented that the door alarm sounded when the licensed nurse wheeled the resident back into the facility (indicating R172's wander management bracelet was working properly). When asked what happened, R172 verbalized in her native language, someone held the door open for me and assisted me back home. On 01/08/26 at 09:03 AM, an interview, concurrent observation, and record review were conducted with Director of Maintenance (DOM) and Maintenance Supervisor (MS) regarding the facility's wander management system and the door alarms. DOM reported that only a limited number of residents (fewer than ten) wear wander management bracelets that activate the system near facility exits.Concurrent observation of exit doors equipped with the wander management system revealed a green indicator light on top of the doors that changed red as the bracelet approached the doors. DOM demonstrated that when a resident wearing a bracelet approaches an exit, the door automatically locks, but no alarm will sound. An alarm sounds only if the resident attempts to open the door, and the door will open after approximately 15 seconds of continued pressure. During, observation, DOM pushed the door for approximately 15 seconds and exited the facility, at which time the alarm increased in frequency and volume. DOM further explained that if doors were ajar and unable to lock, an alarm will sound upon exit. The alarms would only shut off when a staff member enters a code.Concurrent review of the facility's monitoring log for operation of door monitors (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and wander management system showed routine weekly checks with no identified issues prior to the incident including checks completed prior to the incident on 12/02/25 and post-incident on 12/09/25.Review of R172's nursing tasks documented R172 had her bracelet with her and was functioning on 12/06/25.On 01/09/26 at 09:01 AM, an interview was conducted with Director of Nursing (DON) and Administrator. DON and Administrator reported that during their investigation they learned that a visitor of another resident had been talking with R172, who requested assistance getting to her home. The visitor was unaware of facility protocols for residents leaving the building and did not notify staff. The visitor assisted R172 and walked her to her family member's home located next to the facility's entrance driveway. Administrator confirmed that staff were unaware R172 was missing until her son called the facility. When asked how R172 was able to leave the facility without staff intervention, the Administrator reported that a staff member heard the door alarm, did not observe any residents in the immediate vicinity, and shut the alarm off. When further asked whether staff were required to immediately check all residents wearing wander management bracelets after hearing an alarm without identify a resident nearby, DON stated that such check were not part of the facility's protocol. DON further stated that the facility only initiates a search once a resident is identified as missing and acknowledged this may need to be addressed moving forward. Review of the facility's Elopement policy and procedure, effective 10/01/24, revealed that the outlined procedures are implemented only after it has been established that a resident is missing. The policy does not include procedures for staff response when the wandering management system alarm is activated, and staff are initially unable to identify a missing resident nor does it include a process to ensure residents wearing wander management bracelets are immediately accounted for.