

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 10/18/2024
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 42160 Based on interviews and record review, the facility failed to ensure the resident's right to be informed in advance, of the risk and benefits of the use of a psychotropic medication, and consent to treatment for two of five (Resident (R)134 and R141) sampled. R134's Resident Representative (RR)4 was not aware that the resident was receiving duplicate antidepressant therapy. RR4 confirmed the risk/benefits, education was not provided to RR4 regarding duplicate antidepressant therapy and did not sign a consent form. Requested a consent form from the facility and the facility confirmed a consent form was not obtained from RR4. As a result of this deficient practice, residents are at risk for more than minimal harm. Findings include: 1) On 10/16/24 at 10:13 AM, conducted an interview with R134's Resident Representative (RR)4. During the interview, inquired about the three large bandages on R134's head. RR4 reported R134 frequently scratching and picking at his skin, on his head. Asked RR4 what interventions are the facility implementing for R134's scratching/picking behavior. RR4 confirmed being R134's healthcare decision maker and stated they are covering the area with bandages. Asked RR4 if R134 was on a medication to help with the resident's scratching/picking behavior. RR4 reported R134 is taking melatonin for his sleep and something else to help the resident with eating but could not remember the name of it. This surveyor informed RR4 that this surveyor was going to list several antidepressants and if RR4 recognizes any of these medications, to let this surveyor know. RR4 agreed, then listed the following medications: Celexa also known as citalopram (generic name); Lexapro also known as escitalopram (generic name); Remeron also known as mirtazapine (generic name); ; and Zoloft also known as sertraline (generic name). RR4 reported mirtazapine sounded familiar and it's to help with R134's appetite, but the other medications did not sound familiar. This surveyor informed RR4 that R134 has been receiving Lexapro also known as escitalopram since 08/17/24 and the medication is another group of antidepressant medication. Inquired if RR4 recalls signing a consent form and/or education on the risk and benefits of Lexapro. RR4 confirmed he recalls a consent form for melatonin and Mirtazapine for R134's appetite (which RR4 confirmed was recently increased) but did not complete a consent form for Lexapro. RR4 did not recall the facility informing him about the Lexapro prior to R134 receiving the medication and was not informed of R134 being on two different types of antidepressants. (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
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R134's Electronic Health Record (EHR) on 10/16/24 at 09:54 PM, documented a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD)) on 09/15/24, documented Section C. Cognitive Patterns, Brief Interview for Mental Status (BIMS) score was 4, indicating the resident has significant cognitive impairment. R134 had a physician's order for an antidepressant, Lexapro tablet, 5 milligrams (mg) by mouth (PO) once a day, started on 08/17/24 at 08:00 AM and is open ended (no stop date), with a diagnosis of skin picking disorder. Review of the EHR did not include an Informed Consent for Psychotropic Medication-Antidepressant form for the use of Lexapro. R134's progress notes documented two progress notes, in which the first progress notes documents, on 08/16/24, prior to administration of the medication, evening staff endorsing to day shift to update the family. Then on 08/17/24 during day shift, the facility attempted to call POA (RR4) regarding new orders. There is no documentation after the 08/17/24 progress note documenting the facility got a consent, was updated, or was explained the risk/benefits of Lexapro, until 10/17/24 at 01:08 PM, which is after this surveyor completed an interview and concurrent record review of R134's EHR with the Unit Manager (UM)4 regarding a consent form for the use of Lexapro. - On 08/16/24 at 22:02 (10:02 PM) .Start Lexapro 5 mg q AM (every morning). Endorsing day shift to update the family. - On 08/17/24 at 01:09 PM, was edited, on 08/17/24 at 06:23 PM, to include At 1310 (01:10 PM) Attempted to call POA but LM regarding new orders. On 10/17/24 at 09:46 AM, conducted a concurrent interview and record review of R134's EHR with UM4. Requested to review R134's Informed Consent for Psychotropic Medication- Antidepressants form for the use of Lexapro. UM4 reviewed R134's EHR and could not locate an informed consent for the use of Lexapro for R134. Requested and provided UM4 an opportunity to provide any other form of documentation that RR4 was informed of the risk/benefits for Lexapro and consented to the treatment. UM4 confirmed the facility did not have any documentation, verbal or written, that RR4 consented to or was informed of the risk/benefit of R134 taking Lexapro prior to staff administering the medication to the resident. In the afternoon on 10/17/24, this surveyor returned to the conference room and reviewed documentation of R134's use of Lexapro. These documents were completed by the facility after this surveyor's concurrent interview and record review of R134's EHR with UM4, during which the facility became aware of the deficient practice and was unable to provide documentation of an informed consent and education on the risk/benefits prior to administering the medication to R134. These documents were: - A progress note written on 10/17/24 at 01:08 PM documented, This LN (licensed nurse) called POA (Power of Attorney, (RR4)) about Lexapro 5 mg for skin picking disorder, POA stated, Yeah, I'm aware that he's taking that medication. I gave consent. CN TR aware. - An Informed Consent for Psychotropic Medication- Antidepressants, dated 10/17/24 at 01:20 PM, and did not contain RR4's signature or staff attestation that RR4 provided a verbal consent. 2) Conducted a review of R141's EHR on 10/16/24 at 10:15 AM. Review of R141's physician's orders documented an order for Mirtazapine tablet; 7.5 mg; amt: 7.5 mg; oral Special Instructions: poor po intake Once a Day 20:00 (08:00 PM) was started on Review of R141's EHR did not contain documentation of an Informed Consent for Psychotropic Medication- Antidepressant for the use of Mirtazapine. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 02:55 PM, requested a copy of R141's Informed Consent for the use of Mirtazapine and documentation of education for the risk/benefits of the medication completed by the resident or RR3. The Director of Nursing (DON) confirmed there was no informed consent of Mirtazapine for R141. During an interview and concurrent record review of R141's EHR with UM4 on 10/17/24 at 08:28 AM, reviewed the Physician's Orders which documented an open order started on 09/24/24 for Mirtazapine 7.5 mg once a day. UM4 reviewed the progress notes and other parts of the EHR and confirmed it did not contain documentation of a consent form or education on risk versus benefits was completed by R141 or RR3 for the use of Mirtazapine. UM4 confirmed R141 received Mirtazapine without a completed informed consent. Review of the progress notes documented the first dose of Mirtazapine administered to R141 was on the evening shift and the informed consent was endorsed to the morning shift the next day, and the consent form was not completed. After it was confirmed by UM4, there was no consent form for the use of Mirtazapine for R141, a Late Entry on 10/17/24 at 01:39 PM for consent for the use of Mirtazapine was entered into R141's progress notes.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review (RR), the facility failed to provide a resident-centered environment for 2 of 2 Residents' (Residents 28 and 67) sampled for accommodation of needs, by not utilizing a shower chair for Resident (R)28 that fit her comfortably and allowed her to shower thoroughly, and failing to ensure that R67's call light was always placed within her reach and line-of-sight. As a result of this deficient practice, these residents were hindered from attaining their highest practicable well-being. Findings include: 1) Resident (R)28 is a [AGE] year-old female admitted to the facility on [DATE]. R28 has an active diagnosis of morbid obesity. On 10/16/24 at 08:51 AM, an interview was done with R28 at her bedside. When asked about her showers, R28 stated that she showers 2-3 times a week in a small shower chair in the bathroom of her room. R28 stated that the shower chair in her bathroom feels kind of small, and she would like to have a bigger one, describing the shower chair as uncomfortable, pressing into her on each side. R28 explained that the standard-sized shower chair does not allow her to open her legs to wash while seated so she usually does not feel completely clean after a shower. R28 further stated that there is a larger shower chair that she has used before, but it requires staff to take her to the nearby shower room as opposed to showering in her own bathroom. R28 also stated that she was unsure if the shower room was even used by staff anymore because there is a lot of stuff in there. Observation done of R28's bathroom confirmed the standard-sized shower chair just fit in the shower stall and the tiled walls enclosing the shower stall did not allow any room to maneuver for a resident who filled up the shower chair. On 10/16/24 at 09:14 AM, an interview was done with Licensed Practical Nurse (LPN)1 outside the unit's shower room, which was less than 200 feet from R28's room. Concurrent observation of the shower room with LPN1 confirmed that it was filled with storage items. LPN1 stated that the room was no longer used for showers and was just used for storage. Asked if there was a larger shower chair stored in the room as one could not be seen from the doorway. LPN1 stated she did not know. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 01:23 PM, interviewed Senior Certified Nurse Aide (CNA)2 near R28's room. CNA2 confirmed that there is one larger shower chair that is kept in the shower room. Stated that R28 is showered on the evening shift and that the CNAs on the evening shift should be taking the larger shower chair into R28's bathroom whenever they shower her. Agreed that the standard shower chair would not be comfortable for a resident of R28's size. Asked CNA2 if the larger shower chair would fit in R28's bathroom. CNA2 stated it should. CNA2 retrieved the larger shower chair from the shower room, which she confirmed had been cleaned since the state agency observation the previous morning and tried to wheel it into R28's bathroom shower stall. CNA2 verified and confirmed that the larger shower chair did not fit all the way into the shower stall so that it could be positioned under the shower head. CNA2 agreed that meant the larger chair was probably not being used to accommodate R28 for her showers. When specifically asked, CNA2 stated that she was surprised the evening shift CNAs would ask R28 to squeeze onto the smaller (standard-sized) chair. CNA2 agreed that the smaller chair in the small shower stall would make it difficult for R28 to get thoroughly clean as it did not allow for R28 to open her legs, bend forward, or maneuver. Review of R28's Comprehensive Care Plan revealed the following under Baseline Needs: Help me maintain dignity by assisting with . maintaining good hygiene. 48351 2) R67 is an [AGE] year-old female admitted to the facility on [DATE]. R67 has a medical history that includes, but not limited to, chronic obstructive pulmonary disease, dependence on supplemental oxygen, acquired absence of eye, and anxiety disorder. R67 had an annual assessment on 08/14/2024. During the assessment R67 had a Brief Interview for Mental Status (BIMS) score of 15, which means R67 is cognitively intact. Concurrent observation and interview were conducted on 10/15/24 at 10:27 AM in R67's room. R67 was laying in bed. R67's call light was laying on a chair that was against a wall. R67 was not able to reach her call button. R67 asked State Agency (SA) if he/she can hand her the call light. R67 stated that she can call for help, but frequently the call light is not nearby for her to use. Observation was conducted on 10/17/24 at 09:08 AM in R67's room. R67 was laying in bed and asked SA if he/she has seen her call light. SA observed R67's call light laying on the floor. Interview was conducted with the Director of Nursing (DON) on 10/18/24 at 10:53 AM. DON confirmed that call lights should always be accessible for residents to use. Facility policy titled, Call Light, Use of, dated 06/12/23, was reviewed. Policy noted, 11. Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand or clipped to the guest/resident or placed in reach when sitting up.		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 42160 Based on interviews and record review, failed to ensure one resident's right to be free from abuse. R106 hit R141 in her legs with his wheelchair, then left laughing. R141 sustained a 10 cm x 10 cm blue/purple discoloration on the left medial knee and 0.5cm x 0.5 cm light red mark on the left leg just below knee and reported to staff that she was going to her room because she was feeling unsafe because R106 hit her. As a result of this deficient practice, residents in the presence of R106 have the potential for abuse and more than minimal harm. Findings include: Review of the Facility Reported Incident (FRI) #11157, documented on 08/21/24 at 01:15 PM, R141 reported R106 hit her with his wheelchair, reversed the wheelchair then propelled away from the resident laughing. R141 reported that both resident's knees contacted each other when R106 banged her. Staff assessed R141 and documented a 10 cm x 10 cm blue/purple discoloration on the left medical knee and 0.5 cm x 0.5 cm light red mark on the left leg just below R141's knee. R141 reported that she does not feel safe and R106 intentionally hit her and R141 did not report it to staff at the time of the incident but reported the incident due to bruising and fear of her safety. The facility reviewed and revised both resident's care plans and R106 was immediately moved to another unit for R141's safety. At the time of this surveyor's investigation, the facility had corrected the deficient practice and ensured residents with contact with R106 remained safe and free from abuse and found this deficient practice to be past non-compliance and no Plan of Correction is required for this citation.		

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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. 43245 Based on observation, interview, and record review, the facility failed to implement a person-centered Comprehensive Care Plan (CP) for one resident in the sample (Resident 98). Despite identifying Resident (R)98 as an accident/safety hazards risk due to his smoking and behaviors, and after multiple documented incidents related to his smoking and behaviors surrounding his smoking, R98's smoking CP was not implemented consistently. As a result of this deficient practice, R98 was placed at risk for additional altercations related to his behaviors surrounding smoking. Findings include: On 04/05/24 the state agency (SA) received a facility-reported incident (FRI) ACTS #10878, describing a physical altercation between Resident (R)98 and R448 related to both residents smoking behaviors. An investigation into the FRI during the recertification survey conducted on 10/15/24 - 10/18/24 found deficient practices related to the incident. On 10/15/24 at 03:15 PM, observed R98 sitting in the designated smoking area alone with no staff present. On 10/16/24 at 10:01 AM, observation was done of R98 in the designated smoking area, however he was not smoking. No facility staff present. SA was stopped just outside the designated smoking area by two other residents who wished to remain anonymous. Anonymous Resident (AR)1 stated that R98 had hit him before related to his smoking behaviors and complained that R98 stays in the designated smoking area even when he has nothing to smoke. AR1 and AR2 both stated that R98 roots through the ashtray even though no one is supposed to do that, searching for cigarette butts that can still be smoked, then throws the nubs down on the ground. Both reported that R98 often asks others for cigarettes despite knowing that behavior is not allowed. AR1 and AR2 stated they wait outside the designated smoking area whenever R98 is there because they do not want any trouble, or for R98 to ask them for cigarettes. Made observation of the ashtray in the designated smoking area, opened, with butts on the ground beneath R98's wheelchair, but none under the wheelchair of a female resident who was smoking at the time and sitting closer to the ashtray than R98 was. On 10/16/24 at 10:06 AM, interviewed Housekeeper (HK)1 who was emptying the trash cans along the sidewalk leading to the designated smoking area. HK1 confirmed that she cleans the designated smoking area daily. When asked about the ashtray in the designated smoking area, HK1 confirmed that the ashtray is supposed to be locked but she finds it opened with butts on the ground on a daily basis. On 10/16/24 at 10:13 AM, an interview was done in the North unit breezeway with Registered Nurse (RN)1 after observing him picking R98 up from the designated smoking area and taking him back to his room. RN1 stated that he was alerted by Certified Nurse Aide (CNA)3 that R98 was out smoking, so he went out to pick him up. When asked if R98 was allotted a specific time period to smoke, RN1 answered no, and stated that when R98 is out smoking we frequently monitor [R98] specifically because of his history of problems with other smokers. When asked to describe what frequently monitor meant, RN1 stated they check on him every so often when they know that he is out there. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 10:18 AM, during an interview with Unit Manager (UM4) in the North unit breezeway, UM4 confirmed that residents should not be asking other residents for cigarettes or smoking supplies, nor should they be rooting through the ashtray for cigarette butts. On 10/16/24 at 10:24 AM, an interview was done with Licensed Practical Nurse (LPN)1 in the North unit breezeway. LPN1 confirmed that R98 did not have any cigarettes to smoke and that he did not request any cigarettes or ask for his lighter from her that morning. Agreed that without anything to smoke, R98 should not be out in the designated smoking area. Review of R98's Comprehensive Care Plan (CP) revealed the following interventions: Remind me that asking others to purchase or bum cigarettes is not an allowed practice. Remind me that I need to wear a smoking apron, as I often forget to do so. I will ensure I have nursing escort when I go smoke to ensure other residents are kept safe. R98 had two goals in his CP: I will follow the facility smoking policy. Resident will smoke safely and supervised in designated area with supervision. On 10/18/24 at 11:05 AM, an interview was done with the Administrator in her office. The administrator stated that on 05/01/24, a staff escort was added to R98's CP. The Administrator explained that meant the expectation is that staff who knows that he is out there, stays with him the entire time he is smoking, and brings him back into the facility.		

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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** 38870 Based on observation and record review, the facility failed to revise the care plan for one Resident (R)32 to provide the support needed when he leaned over in his wheelchair. Findings include: Cross reference to F684. R32 is an [AGE] year-old male admitted to the facility on [DATE]. Primary diagnosis includes Parkinson's disease and unspecified dementia per review of the facesheet. Random observations on the East dining/ activity area on the following dates, 10/15/24 at 09:16 AM; 10/16/24 at 10:30 AM; 10/16/24 at 2:19 PM; 10/17/24 at 10:14 AM; and 10/17/24 at 2:04 PM. Observed R32 sitting in a high back wheelchair, his neck bent to the right side leaning over and sleeping. Care plan reviewed. Approach start date 09/19/2024. I have a tendency to lean over in my wheelchair (WC) or have my head to the side sleeping in my WC. Assist me to upright position and use my cushion to support as I allow .		

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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** 38870 Based on observation, interview and record review, the facility failed to provide one resident with support of the head and neck while sitting in his wheelchair. The resident sleeping in his wheelchair slumped over to the right side throughout the day. The deficient practice affected one resident in the sample's quality of care. Findings include: Cross reference to F657 R32 is an [AGE] year-old male admitted to the facility on [DATE]. Primary diagnosis includes Parkinson's disease and unspecified dementia. Random observations on the East dining/ activity area on the following dates, 10/15/24 at 09:16 AM; 10/16/24 at 10:30 AM; 10/16/24 at 2:19 PM; 10/17/24 at 10:14 AM; and 10/17/24 at 2:04 PM. Observed R32 sitting in a high back wheelchair, his neck bent to the right side leaning over and sleeping. Interview with Licensed Nurse (LN) 35 on 10/18/24 at 11:35 AM to discuss the care plan for R32. LN35 stated that we don't have care planned interventions for support when he leans over in his chair, but he has a cushion for his back support.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on observations, interviews, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment to prevent urinary tract infections. R180's catheter tubing was observed to have sediment and blackish growth on the sediment throughout the entire length of the tubing. Review of R180's Electronic Health Record (EHR) did not contain an order for treatment of sediment and blackish growth in the catheter tubing. As a result of this deficient practice, residents with catheters are at risk for more than minimal harm. Findings include: On 10/15/24 at 01:20 PM, conducted an observation and interview with R180 in the resident's room. While conducting the interview, observed R180's catheter tubing with copious amount of sediment and blackish growth throughout the catheter tubing. Resident stated the last time his catheter was changed was 3 weeks ago and prior to that, he had the same catheter and tubing for 3 months. Inquired if staff said anything to the resident regarding the tubing sediment and if staff had discussed care related to the sediment. R180 confirmed staff had not discussed or informed the resident that the sediment was something that needed to be addressed. Inquired if staff had ever flushed the catheter tubing when providing care. R180 confirmed staff has not flushed the catheter tubing or discussed flushing the tubing as a means to clear out the sediment. R180 reported he was thinking about asking staff to change the tubing due to the visible sediment and blackish growth within the tubing, resident stated, It (the sediment) doesn't look like something you want in the tubing that goes into your bladder. Review of R180's EHR documented the resident was admitted to the facility on [DATE], with a catheter. Review of the physician's orders documented an order started on 09/17/24 for Foley catheter care, special instructions to monitor for signs and symptoms of infection, leakage, and urine output. Notify provider if no urine output in eight hours. R180 did not have an order to flush the catheter or for care/treatment of observed sediment. On 10/17/24 at 08:52 AM, conducted concurrent record review of R180's EHR and interview with Unit Manager (UM)4. UM4 reviewed R180's EHR and confirmed there were no orders or plan of care to address the copious amount of brown/tan sediment with blackish growth throughout the catheter tubing and could result in R180 developing an infection of the urinary tract or bladder. During the interview, R180 came into the nursing station and UM4 viewed the resident's catheter tubing. UM4 confirmed R180's catheter tubing contained more than normal or desired sediment and confirmed that the blackish coloring was indicative of bacterial or fungal growth and was not appropriate. UM4 stated that staff will need to be reeducated on catheter care and what should be assessed when providing care because the amount of sediment and growth could easily be seen and should have been addressed but was not.		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on observations, interview, Electronic Health Record (EHR) review and policy review the facility failed to assess pain prior to and manage one Resident (R) of the sampled, R252's pain during a dressing change for his stage 4 pressure ulcer (PU) on his right buttock. The deficient practice prevented R252 from attaining and maintaining his highest level of wellbeing. Findings Include: On 10/17/24 at 01:40 PM spoke with Registered Nurse (RN) 26 and inquired if she had done the dressing change for R99. She confirmed she had already done the dressing change to R99's feet/legs. Inquired if she was going to do a dressing change soon and RN26 stated she was going to do a dressing change for R252. On 10/17/24 at 01:50 PM observed dressing change for R252's stage 4 PU to his right buttock. RN26, RN30 and Advance Practice Registered Nurse RX (APRN RX) 1 were present in R252's room for the dressing change. R252 was assisted with turning onto his left side by RN26 and RN30 and his clothing and adult brief was pulled down to expose his right buttock. Dressing to R252's right buttock was intact and RN30 told R252 she was going to remove the dressing. RN30 removed the top of the dressing to expose R252's skin and wound packing that was in place. RN 30 and RN26 switched places. RN30 was now facing resident and RN26 was behind R252. RN26 started to remove the packing from R252's wound and resident could be heard crying and saying repeatedly It hurts! It hurts! It hurts! R252 was also observed extending his right arm and balling up his fist a couple of times (not to hit anyone) as he cried. RN30 told resident You're ok. APRN RX1 inquired when resident was last medicated for pain and RN26 responded around 9 am. RN26 continued with dressing change by cleansing the wound bed with Dakin's Solution (sodium hypochlorite) 0.125% and packed the wound bed with 1/4 strength Dakins moistened gauze. R252 continued to cry. RN26 covered the wound with an abdominal pad and applied tape. R252 was turned to his back by RN26 and RN30 and repositioned in his bed. APRNRX1, RN26, and RN30 left R252's room. R252 was interviewed at this time. R252 had his eyes closed and was crying. R252 was encouraged by surveyor to take deep breaths which he did. R252 was able to calm down and talk with surveyor. Inquired with R252 if he was medicated or offered pain medication prior to the dressing change and he said, no I forgot to ask the staff for the medication and he stated it was my fault. Resident was reassured this was not his fault. Surveyor asked R252 what his pain was at on a scale of 1-10 and resident stated, 8 or 9. On 10/17/24 at 02:05 PM interviewed RN30, who is the unit manager. Inquired what stage R252's PU is and RN30 stated it is a stage 4 PU, that it was on his admission paperwork yesterday when he was admitted . Inquired if she would medicate a resident prior to a dressing change and RN30 stated not necessarily. Inquired if she would premedicate a resident who has a stage 4 PU before a dressing change and she said yes. (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 10/17/24 Record Review (RR) of R252's EHR revealed R252 is a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnosis that includes, but are not limited to, pressure ulcer of right buttock, stage 4; insomnia, unspecified; and pain, unspecified. R252 weighs 95.2 pounds. Review of R252's Care Plan (CP) revealed Problem Start Date 10/17/2024 Category: Pain I am at risk for acute/chronic pain that may affect my wellbeing. Goal Target Date: 01/17/2025 will have relief from pain within one hour of PRN pain medication administration. Approach Start Date: 10/17/2024 Administer pain medications as ordered, see MAR (Medication Administration Record). Assess and provide pre-medication as indicated prior to activities, therapies, procedures, treatments to optimize my function and comfort. Assess me for breakthrough pain and provide PRN analgesics as ordered. Document the effectiveness on MAR. Assess the effectiveness of the medication, current treatment regime, and the impact of the pain management program on me. Assess the impact of acute/chronic pain on my function and wellbeing. Notify MD for concerns Assess the location, severity, duration, time of onset, and pattern of my pain. Observe me for signs of non-verbal expression of pain, such as grimacing, crying, guarding, rocking, etc. Last reviewed/revised on 10/17/24 at 09:55 AM by RN35. Review of R252's Brief Interview for Mental Status (BIMS) dated 10/17/24 with a score of 13 out of 15 identified him as cognitively intact. Continuation of RR revealed medications ordered to control R252's pain include the following: Oxycodone 5 mg tablet 1 tablet by mouth every 4 hours PRN (as needed) for moderate - severe pain. R252 received this medication on 10/16/24 at 20:24 (08:24 PM) for pain he rated a 6 out of 10 and the medication was documented as NE (Not Effective). Morphine concentrate solution 100 mg/5 ml (20 mg/ml) amount to administer 5 mg oral every 4 hours PRN (as needed) Dx: Pain, Unspecified. This was given on 10/17/24 at 01:59 AM, at 09:14 AM and at 14:03 (2:03 PM) for pain and documented as E (Effective). R252 also has an order for Pain monitor Q (every) shift. R252's pain was documented with no pain on 10/16/24 evening shift, had 10 out of 10 pain to his peri area/buttocks on 10/16/24 night shift and 9 out of 10 pain to his coccyx on 10/17/24 day shift. Continued RR on 10/17/24 found RN26 documented in R252's EHR a progress note with a date and time of 10/17/2024 at 14:29 (02:29 PM) Res (Resident) A&Ox4 (Alert and oriented X4). Calm and cooperative with care. Compliant with medications. Denied therapy d/t experiencing pain. No facial droop noted. Bilat hand grip equal in strength. Speech clear, medications taken W/T w/ no concerns or difficulty swallowing. Res (Resident) up in WC throughout shift. Res (Resident) c/o pain 5/10 while laying in bed, requested morphine. Morphine concentrate 5mg given at 0914 (09:14 AM) w/ positive effect. Frequent rounding completed, no signs of distress noted. Sacral wound dressing change completed as ordered. Cleansed with 1/4 strength Dakins, gently pack wound bed w/ moistened gauze and cover with ABD pad. Res (Resident) grimacing during change but no request to stop. Upon assessment post dressing change, res (resident) reported 9-10/10 pain. Morphine concentrate 5mg given at 1403 with positive effect. Safety precautions maintained. Call light within reach while in bed. please refer to CNA charting for ADLs. (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Continuation of RR on 10/17/24 of R252's EHR found RN30 had written a progress note that was dated and timed 10/17/2024 at 15:43 (03:43 PM) which stated This RN observed wound care for res (resident) to R (right) buttock stage IV. LN (Licensed Nurse) (staff's initials) conducted wound care tx (treatment) with this RN and APRN (staff's initials) present. Noted to be passed out initially, res (resident) verbalized, I was passed out. Noted to be in pain during middle of wound care visit while this RN and LN (staff's initials) repositioned him. Wound noted to be clean. No odor noted. Res (Resident) able to tolerate wound care tx (treatment) with therapeutic communication, reminded that tx (treatment) is being provided and that he is OK and was crying by verbalizing ow, ow, ow. Res (Resident) stopped crying out after repositioning completed and staff able to complete wound care tx (treatment). Resident appeared to have fallen back asleep. APRN (staff's initials) notified regarding pain - will offer prn pain meds prior to wound care. Continue with Q2 hour repositioning with cushion under [NAME]. Verbalize understanding. Continue to monitor. On 10/18/24 at 08:25 AM interviewed unit manager, RN30. Inquired about R252's pressure ulcer and RN stated it was her first time seeing the resident's wound. RN30 stated R252 has a stage 4 pressure ulcer to his right buttock. Inquired if RN30 could explain what it meant when a resident has a stage 4 pressure ulcer and RN30 stated there is a wound bed and things can be seen. Asked RN30 to explain the difference between a stage 2 and a stage 4 pressure ulcer and she was able to share the stage 2 pressure ulcer has some skin breakdown and the stage 4 has a wound bed and things can be seen such as bone. RN30 shared that sometimes people don't feel sensation or pain with this type of sore. RN30 stated R252 is new to her. Inquired of RN30 what the routine procedure would be for doing a dressing change with someone who has a stage 4 pressure ulcer. RN stated, assess for pain. Inquired if this was done with R252 and RN30 stated no that he had received medication earlier at around 9 am. RN30 stated she had to tap the resident and say his name to arouse him before the dressing change. Inquired if she would assess for pain prior to dressing change and she said yes. RN30 stated if you have medications you can give it and then get everything ready for the dressing change. RN30 stated they could have given R252 the fast-acting morphine prior to the dressing change. Inquired of RN30 if this was a liquid form and she confirmed it is. RN30 confirmed this was not done for the resident prior to the dressing change on 10/17/24. On 10/18/24 at 09:10 AM requested from Administrator copies of all Medical Doctor (MD) and/or APRN progress notes written for R252. Also requested facility policies and training on wound care and pain management. Requested dates nursing staff completed these trainings. Administrator provided these soon afterwards. On 10/30/24 review of SNF Visit Note written by APRN RX1 which was signed electronically on 10/23/24 at 03:47 PM for Date of Encounter: 10/17/2024 included . 2. Subjective: 74 yo male patient presents for SNF tuck in visit. He is observed resting quietly in bed without signs or symptoms of pain or discomfort. Multiple attempts to wake him made with RN at bedside. He does wake up with physical stimuli and states i was passed out. Patient is agreeable to dressing change at this visit. Myself, RN (Staff's first name) and RN (Staff's first name) at bedside for wound evaluation and dressing change. Patient able to independently reposition BLE (bilateral lower extremities) and BUE (bilateral upper extremities) for wound care. Wound packing removed with mild discomfort. Wound cavity assessed and re-packed. Patient with mild discomfort but tolerable. Dressing change completed. Review of facility policy titled Skin Management System with revision date 11/2/23 states Licensed nurses will: a. Assess all residents for pain and treat the resident accordingly before, during and after treatments as needed. (continued on next page)		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of facility staff Skin and Wound Care training revealed RN30 did this training on 12/26/23. RN26's name was not listed as completing this training. The training discusses Stage 4 PU identifying it as: Full thickness skin loss with exposed or directly palpable fascia, bone, tendon, ligament, cartilage or muscle Slough or eschar may be present on some parts of the wound bed Often include undermining and tunneling Treatment for PU in the Skin and Wound Care training included: Considerations Etiology of the wound Characteristics of the wound Location of the wound Goals and preferences of resident/representative (healing vs palliation/comfort) Manage tissue load Wound care Pain management Review of facility policy titled Pain Management Policy with a revision date of 07/12/2023 states Effective pain recognition and management requires an ongoing facility-wide commitment to resident comfort, to identifying and addressing barriers to managing pain, and to addressing any misconceptions that residents, families and staff may have about managing pain. Nursing home residents are at high risk for having pain that may affect function, impair mobility, impair mood, or disturb sleep, and diminish quality of life. The onset of acute pain may indicate a new injury or a potentially life-threatening condition or illness. It is important, therefore, that a resident's reports of pain, or nonverbal signs suggesting pain, be evaluated. 7. Patient/Resident should be evaluated for any needed pain medication prior to, during and after treatments (i. e. wounds),care and/or therapies. Review of facility Pain Management Program with a revision date of 07/12/2013 states The first step in the management of pain is the recognition of pain. Is pain present? The patient/resident is evaluated for pain upon admission, during periodic scheduled assessments, before, during and after therapies and treatments and whenever a change occurs in their condition (e.g., after a fall or other trauma or when a change occurs in the patient/resident's behavior, daily routines or mental status). Nonspecific and often nonverbal signs that may suggest the presence of pain include: . Fidgeting, increasing or recurring restlessness . Sighing, groaning, crying, breathing heavily .		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43245 Based on observation, interview, and record review, the facility failed to implement a thorough process to assure accurate reconciliation and accounting for all controlled medications, for 1 of 16 medication carts, in order to promptly identify loss or potential diversion. Findings include: On 10/17/24 at 08:55 AM, an inspection of the North Team 2 medication cart was done with Registered Nurse (RN)3. During a review of the Narcotic Signature Sheet, noted that the oncoming day shift nurse, RN3, had not signed or initialed it yet to attest and verify that the narcotic count was correct. RN3 confirmed that the narcotic count is done at the start of every shift, completed by both the off-going and on-coming nurse, and signed by both. RN3 verified that the off-going nurse had signed it, but she had not. At first, RN3 stated that she usually sign it before the end of my shift. After further questioning however, RN3 confirmed that she should have signed it as soon as the count was done, and agreed that with only one initial, it makes it appear as if the off-going nurse did the count by herself. Review of Medication Storage Controlled Medication Storage policy and procedure, last revised 01/24, revealed the following: At each shift change or when keys are surrendered, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses or approved individuals per state regulation and is documented on the controlled substance accountability record or verification of controlled substances count report.		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on observation, interview, and record review, the facility failed to manage and monitor the medication regimen for one Resident of five in the sample by implementing a gradual dose reduction (GDR) for use of an antipsychotic or provide the clinical rationale from the physician that it was not recommended. The deficient practice failed to promote the residents highest practicable mental, physical, and psychosocial well-being. Findings include: Resident (R) 32 is an [AGE] year-old male admitted to the facility on [DATE]. Primary diagnosis includes Parkinson's disease and unspecified dementia per record review of the annual Minimum Data Set (MDS). Random observations of R32 on the East dining/ activity area on the following dates, 10/15/24 at 09:16 AM; 10/16/24 at 10:30 AM; 10/16/24 at 2:19 PM; 10/17/24 at 10:14 AM; and 10/17/24 at 2:04 PM. Observed R32 sitting in his wheelchair at the table sleeping or sitting quietly. No aggressive behavior observed. Record review dated 09/18/24. R32 takes the following medications: Seroquel (an antipsychotic) 25 milligrams (MG) every evening. Start date 06/21/2022. MDS annual assessment dated [DATE] reviewed. Brief Interview for Mental Status (BIMS) 99- severely impaired cognition. No behaviors or depression/ mood coded. The GDR for the Seroquel; the Medication Regimen Review (MRR) and behavioral monitoring sheets from 07/2024 to 10/2024 requested from the Director of Nursing (DON) on 10/17/24 at 11:30 AM. Behavior monitoring flowsheets from 07/01/24 to 10/17/24 reviewed. The following behaviors are being monitored (hitting, paranoia, attempting to pull g tube/ un redirectable. Frequency how often behavior occurred & intensity how resident responded to redirection. Intensity code: 0 did not occur; 1 easily altered; 2 difficult to redirect. 0-behavior did not occur was coded on all days/ shifts and months. Interview with Licensed Nurse (LN) 35 on 10/18/24 at 11:40 AM to discuss R32's behaviors. The surveyor asked LN35 is R32 acts out or shows any aggressive or resistive behaviors. LN35 replied that sometimes he refuses care, and the staff will leave him for a while and approach him later. MRR's reviewed. 08/04/2024- no recommendation. 09/06/2024, no recommendation. 09/29/2024, Please take the following action described below. No report with the recommendation was provided for review. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The GDR and MRR (09/29/2024) report with recommendation for the Seroquel requested from the Regional Nurse Consultant (RNC) on 10/17/24 at 12:55 PM. Received and reviewed the Psychoactive gradual dose reduction (GDR) Evaluation 09/04/24. Medications classification, Antipsychotic and Antidepressant medications reviewed by the inter disciplinary team (IDT). No dosage change recommended for the Seroquel. Confirmed with the RNC that there was no GDR for the Seroquel, only the Citalopram which was recommended by the IDT. Psychotropic medication, use of Policy dated 05/01/2021 reviewed. 6. Residents who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs. 11. The resident's response to the medications, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on observations, interview, record review, narcotic count sheet review and policy review the facility failed to: 1) Label open on dates for five of six blood glucose test strips stored in two medication carts, have a nurse sign the narcotic count sheet when the count was done, store unopened insulin in a refrigerator per manufacture instructions and discard expired medication by the discard by date, 2) Ensure all medications used in the facility were stored in accordance with manufacturer recommendations in 3 of 16 medication carts and 3) Discard an expired medication stored on the storage cart. The deficient practice could affect residents having their blood glucose tested if the strip is expired, affect a resident receiving narcotic pain medication if the count has to be reconciled, affect a resident who is ordered insulin but cannot receive what is on hand due to it being stored incorrectly, affect a resident receiving an expired medication. Proper storage of medications is necessary to promote safe administration practices and decrease the risk of medication errors and/or adverse effects. Findings include: 1) On [DATE] at 09:43 AM observed a medication cart with Registered Nurse (RN) 10. Observed three bottles of blood glucose test strips in a drawer with no opened on date written on the containers. The three bottles were taken out of the medication cart and lined up. All three bottles did not have a seal covering the opening. RN10 confirmed there were no opened on dates on the three bottles and then proceeded to write [DATE] on one of the bottles. Inquired how she knew which bottle she opened and stated because of the placement in the drawer. Below the date opened box, on the blood glucose test strip bottles, the manufacture instructed Use within 90 days (3) months of first opening. On [DATE] at 10:13 AM observed a second medication cart with RN11 who also had three bottles of glucose test strips in the medication cart with two without the opened on date written on the bottles. RN11 confirmed he could not tell if the other containers were opened as there is no seal on the other two undated blood glucose strip containers. 43245 2) On [DATE] at 09:08 AM, an inspection of the North Team 2 medication cart was done with RN3. Observed what appeared to be an unopened box of Humulin R insulin for Resident (R)8 in the top drawer of the medication cart. Concurrent interview with RN3 was done. RN3 agreed all insulin should be refrigerated until opened. RN3 removed the plastic tape on the insulin box, opened the box, and confirmed that the seal on the insulin vial was intact. RN3 reported that she did not know who or when the insulin was placed in the cart. Confirmed that there was also an open vial of Humulin R insulin for R8 in the cart already. On [DATE] at 09:40 AM, during an interview with RN3 in the Nurses' Station, RN3 stated she had put the unopened insulin back in the refrigerator. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy and procedure for Medication Storage, last revised [DATE], revealed the following: Medications requiring refrigeration must be stored in the refrigerator located in the drug room at the nurse's station. 39754 3) Observation of a Medication Storage Cart on [DATE] at 09:00 AM, a bag containing Hydrocortisone 25mg was expired with a label which read discard by ,d+[DATE]. During staff interview on [DATE] at 09:05 AM, RN4 acknowledged that the medication previously mentioned was expired and should have been discarded.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37954 Based on observation and interview the facility failed to store cutting boards and resident plate lids on racks that did not have rust colored debris. This deficient practice could affect all residents who are provided meals from the kitchen, putting them at risk for foodborne illness. Findings Include: On 10/15/24 at 10:04 AM during initial tour of kitchen, a concurrent interview and observation was done. Observation of one rack that had cutting boards stored also had rust colored debris. The Acting Nutritious Services Director stated she would move the (cutting boards) to a different area. On 10/17/24 at 10:50 AM while in the kitchen, to observe the tray line, noticed a rack with rust colored debris that stored the lids for the residents plates. Acting Nutritious Services Director confirmed the rust colored debris and stated she is in the process of replacing both racks.		

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 10/18/2024
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48351 Based on observation, interviews, and record review, the facility failed to ensure proper cleaning procedures for shared equipment were followed by a staff member. This deficient practice promotes the development and transmission of communicable diseases and infections and has the potential to affect the residents in one of the facility units. Findings include: Observation was conducted on 10/18/24 at 09:30 AM. Licensed Practical Nurse (LPN) 2 was seen rolling a vital signs machine into one of the rooms. LPN2 was not observed cleaning the blood pressure cuff with wipes prior to using it on Resident (R) 143. Once LPN2 was done taking R143's blood pressure and other vital signs, LPN2 rolled the vital signs machine towards R181's bed. LPN2 was observed taking R181's blood pressure. LPN2 did not clean the blood pressure cuff in between the two residents. LPN2 then placed the vital signs machine in the hallway. LPN2 did not wipe down the machine and/or attachments prior to parking it in the hallway. Interview was conducted with LPN2 on 10/18/24 at 09:46 AM. LPN2 stated that she should have wiped the blood pressure cuff in between the residents because that is the facility's normal process. Interview was conducted with the Director of Nursing (DON) on 10/18/24 at 10:53 AM. DON confirmed that staff should be wiping down the blood pressure cuffs with each resident. A review of the facility policy titled, Blood Pressure Measurement, dated 06/12/23, was conducted. Policy noted, 16. Sanitize the cuff with sanitizing solution as directed or sanitizing wipe. Allow to dry.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 39754 Based on observation and staff interview, the facility failed to secure a storage room containing Germicidal Bleach Wipes, Surface Disinfectant Wipes and Hand Sanitizing Wipes. As a result of this deficiency, the facility put the safety and well-being of the residents at risk for accident hazards. Findings include: On 10/16/24 at 02:00 PM, the Storage Room near the Ilima Nurse Station was not secured and no staff was in the immediate vicinity to stop anyone from entering the room. A keypad lock was installed on the door, but the door could be opened by just pulling it. The room contained several containers of Germicidal Bleach Wipes, Surface Disinfectant Wipes and Hand Sanitizing Wipes. Staff interview on 10/16/24 at 02:25 PM, Director of Nursing was queried about the previous observation and acknowledged that the Storage Room should have been secured to prevent any unauthorized entry and accident hazards.		