

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2025
NAME OF PROVIDER OR SUPPLIER Maluhia		STREET ADDRESS, CITY, STATE, ZIP CODE 1027 Hala Drive Honolulu, HI 96817	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interview the facility failed to report the results of an allegation of staff to resident abuse, involving Resident (R) 5 and a Certified Nurse Aide (CNA), within five working days of the incident to the State Agency (SA).</p> <p>Findings Include:</p> <p>Review of facility's Initial Event Report submitted to the SA on 02/19/25 for R5 included the following information: Head nurse received call from R5's daughter, very upset and yelling that her dad was not treated properly by the CNA who was assigned to him about 7am this morning. I want to know now the CNA who was assigned to my dad, I want to report and call the social worker. My dad is crying and calling me that he wanted me to pick him up and go home. Head nurse went to talk to R5 and he was able to voiced out his concern. R5 was still very emotional and crying while telling head nurse what happened. I rather go home if you don't like me here. It happened about 7am, I asked the CNA what's her name, she did not tell me, she came to answer my call light but she seems mad and angry. She helped me with my shishi bottle. I told her that I usually have pain in my leg if not positioned properly. It's only her, all of you have been nice and telling me your names. There's always one that differs from the rest, I don't choose who take care of me as long as she don't do it again.</p> <p>On 04/23/25 at 02:28 PM interviewed Administrator in conference room. Inquired about CNA who was named in Event Report submitted to SA on 02/19/25. Administrator stated staff is out on leave, was put on leave the day the incident occurred, 02/19/25.</p> <p>Administrator stated CNA still has to be investigated which is an interview with the law firm the facility has contracted as the third party to perform the abuse/neglect investigations. Administrator stated she always has cases of abuse and neglect investigated by a third party because some of the staff have worked together for a long time with each other. Inquired when the investigation would be conducted as it is already two months since the incident occurred and she stated the law firm is busy but has been notified of the case.</p> <p>Administrator stated if the case is substantiated the facility will do disciplinary action with the staff in question. Administrator confirmed the incident has not been investigated and final report has not been sent to OHCA (Office of Health Care Assurance) within the 5 days per CMS regulation.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled Abuse, Neglect and Exploitation of Residents, Participants, and Misappropriation of Property last reviewed 06/23/23 states . E. Reporting of actual, threatened, or alleged abuse or neglect, injuries of unknown origin and serious injuries 1. Office of Health Care Assurance (OHCA) (Attachment A) Report no later than two (2) hours from when a suspicion of crime has been determined to have been committed against a resident and that the resident sustained serious bodily injury as a result.</p> <p>Report within twenty four (24 hours) any of the following: .</p> <p>b. All allegations of or suspected abuse/ neglect of a resident .</p> <p>Submit preliminary report within 24 hours, and the final investigation report within 5 days.</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility was aware of Resident (R) 7's nut allergy but failed to document severity of nut allergy, failed to develop and implement a care plan for R7's nut allergy and failed to assure all recipes cooked in the kitchen were on the templates reviewed for food allergies before providing food to residents. The deficient practice resulted in harm to R7 who received food that contained nuts and having an anaphylactic response requiring transport to the emergency room for treatment.</p> <p>Findings Include:</p> <p>According to the United States Department of Agriculture (USDA) A food allergy is a potentially serious response to consuming certain foods or food additives. For those who are sensitive, a reaction can occur within minutes or hours, and symptoms can range from mild to life-threatening. The nine leading causes of food allergies identified in the US are milk, eggs, fish, shellfish, tree nuts, peanuts, wheat, soybeans, and sesame. USDA's Food Safety and Inspection Service (FSIS) and the U.S. Food and Drug Administration (FDA) both have laws requiring that all the ingredients in a food product be listed on the food label. https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/food-allergies-big-9</p> <p>Review of facility Event Report dated 03/19/25 for R7 submitted to State Agency (SA) revealed she ate a facility baked and provided dessert at about 01:00 PM and experienced an anaphylactic (severe allergic reaction) response to it. The following information was provided in the Event Report: On 3/19/25 at about 1300 (01:00 PM), resident (R7) called stating that she may have eaten something that she is allergic to. Noted resident's periorbital (refers to the tissues surrounding or lining the orbit of the eye) are slightly reddened. Called MD right away at 1300 (01:00 PM). Received and carried out order for Benadryl 25mg PO Q6 hours PRN (as needed). Called SRN (Nursing Supervisor) to get the Benadryl from the E-kit. VS (vital signs) at 1303 (01:03 PM) are 97.4F (temperature)-87 (pulse)-20 (respiratory rate)-130/67 (blood pressure)-94% (Oxygen saturation) on RA (room air). Noted resident (R7) was anxious and stayed with the resident. Administered the PRN (as needed) Benadryl as ordered upon receipt. Resident (R7) tolerated it. Resident (R7) c/o (complained of) itch to eyes and back. Noted periorbital swelling. Noted desaturation to 84% on RA. Administered oxygen via NC (nasal cannula) at 5L/min. O2 (oxygen) sat (saturation) increased to 94-96%. Updated MD at 1337 (01:37 PM). Received and carried out order to send to ER (emergency room) for anaphylactic shock. Writer called 911 at 1340 (01:40 PM) to give report. SRN (Nursing Supervisor) called the resident's son, at 1341 (01:41 PM) to update him and is agreeable with sending resident to the ER. Fire Department arrived at about 1345 (01:45 PM) followed by ambulance. Per ambulance, not sure what hospital they will go to yet. Resident left via ambulance gurney at 1350 (01:50 PM).</p> <p>On 04/23/25 review of R7's Electronic Health Record (EHR) revealed she was admitted to the facility on [DATE] and her diagnoses include, but are not limited to, other intervertebral disc degeneration, thoracolumbar region; muscle weakness (generalized); unspecified asthma, uncomplicated; essential tremor; and dysphasia (impairment in the production of speech resulting from brain disease or damage).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R7's Minimum Data Set with an Assessment Reference Date (ARD) of 02/19/25 revealed her Brief Interview for Mental Status (BIMS) was 15 which indicates she is cognitively intact. Review of R7's care plan, initiated 02/13/25, did not include a care plan for R7's allergies and need for a therapeutic diet to exclude the food items R7 is allergic to, and did not include interventions to address what to do if R7 is exposed to allergen (food items).</p> <p>On 04/23/25 at 10:53 AM an interview was conducted in the kitchen with the Kitchen Manager (KM). Inquired of KM if R7 had food allergies on her diet and KM was unsure. KM stated following R7's incident, the facility stopped ordering nut items, they are currently a nut free facility. Tour of the kitchen found all nut items had been disposed of and no nut food items were found in the kitchen. Inquired about food item that had been cooked in the kitchen that had been given to R7. KM stated the facility was using a recipe (Jello Cream Cheese Square dessert), from 2019 that included nuts, but they no longer include nuts in this recipe after R7's allergic reaction.</p> <p>R7 was on transmission-based precautions, therefore, on 04/23/25 at 12:44 PM a phone interview was conducted. Inquired if resident had notified facility staff of her nut allergy, R7 stated she gave the list to the dietician and the dietician took notes. Dietician also asked the resident about her food preferences. R7 reported she ate an ice cream dessert with a cookie on the bottom and that was where the nuts were. R7 stated her nut allergy is her most violent allergy. R7 stated on her meal tray that day there was nothing indicating there was anything with nuts on her tray. R7 believes it was hidden with a very small amount in the cookie. R7 stated she reads all the labels on food before she eats anything because it can be lethal.</p> <p>On 04/23/25 at 02:28 PM met with the Administrator in the conference room and requested a copy of admission documents for R7.</p> <p>On 04/23/25 at 03:00 PM an interview was conducted in the conference room with Head Nurse Registered Nurse (RN)3. Inquired if the resident who has a severe allergy to nuts would have a care plan for this and she said yes. Inquired if R7 had a care plan for her nut allergies prior to her being exposed to nuts and she confirmed R7 did not have a care plan for her nut allergy.</p> <p>On 04/23/25 at 03:15 PM Administrator provided copies of requested admission forms filled out for R7.</p> <p>On 04/23/25 at 03:20 PM an interview was conducted in the conference room with the Day Shift Supervisor, RN4. Inquired of RN4 if she did R7's admission intake. RN4 stated she filled out the Pre-admission Notification form for R7. RN4 stated she had received admitting information from hospice which included R7's allergies but not the reaction to the allergens. Inquired who receives the Pre-admission Notification form and RN4 stated the team which included the DON, Social Worker, Doctor, Dietician, etc. Inquired if RN4 spoke with R7 and asked her reaction to her allergies (medications and foods) and she denied this stating this form is for pre-admission and the resident was not at the facility at that time.</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>On 04/23/25 interviewed Dietician at 03:50 PM in the conference room. She provided a copy of R7's updated care plan that was initiated on 03/20/25. Inquired if dietician would initiate a care plan for resident's diet that included restrictions due to allergies and dietician stated she does not open any care plans for food allergies unless they (the resident) are not eating or are losing weight. Dietician stated normally she does not open the care plan for allergies unless it involves their nutritional intake. Dietician stated she talked to resident on 02/13/25 and resident stated she swells up if she eats nuts. Dietician was unsure if she shared this information in the IDT (Interdisciplinary Team) note.</p> <p>Dietician stated she jotted it down on her notes of what resident was stating such as mustard makes her sick, nuts make her swell up. Dietician stated this information was not shared in resident's chart (EHR or hard chart) or with the IDT in her assessment. Dietician explained food item served to R7 that caused the allergic reaction was not on the template used that would show all the ingredients used in the recipe, which would include nuts and that was how the dessert was able to be placed on R7's meal tray.</p> <p>Review of R7's admission documents revealed the Nursing admission Screening History dated and timed 02/13/25 at 14:42 (02:42 PM) did not include any reaction to R7's allergies for prescribed medications and food items resident is allergic to.</p> <p>A review of R7's admission orders dated 02/13/25 included R7's diet but no food restrictions related to her food allergies. R7's allergies were listed and included Famotidine, Penicillin, Phenobarbital, Sulfamethoxazole Trimethoprim, Levaquin, mayonnaise, mustard, nut. The admission orders included R7's allergies but date last reaction and specific reaction was left blank for all the medication and food allergies even though the form states List/circle specific reactions (DO NOT LEAVE BLANK): _____ or anaphylaxis/rash/hives/wheeze/SOB (shortness of breath)/dizziness/CP/syncope (fainting)/N/V (nausea/vomiting) abdominal pain/diarrhea/bleeding/UNK (unknown).</p> <p>Review of Nutrition Assessment for R7 dated 02/25/25 included R7's diet 2/13/25: Regular diet, chopped texture, Regular thin liquids consistency, for Dysphagia; Dietician may order oral supplements as needed. 2/15/25 Regular diet, chopped texture, Regular thin liquids consistency, May have bread products for Dysphasia, unspecified. R7's Nutrition Assessment listed R7's allergies as Multiple nuts, Mayonnaise, mustard, spices, Curry, all salad dressings. R7's Nutritional Assessment did not include her reactions to her allergies. Review of R7's IDT Conf. Notes -V2 dated and timed for 02/14/25 at 08:58 did not include any mention of R7's allergy reaction to her list of medication and food allergies.</p> <p>A phone interview was conducted with RN5 on 04/24/25 at 09:21 AM. RN5 confirmed she was the nurse who did the admission intake for R7. Inquired if she inputted R7's allergies into the EHR and she denied this. Concurrent record review and interview with RN5 revealed Head Nurse RN6 had inputted R7's allergies in the EHR which included nuts. Inquired if other facility staff or R7's family told her R7's nut allergy is bad to the point the resident swells up and RN5 could not recall.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview was conducted on 04/24/25 at 10:28 AM with R7's attending physician. Inquired if Medical Doctor (MD) was aware of R7's nut allergy and he confirmed he was. Inquired if R7 or her son had told MD of her reaction to nuts and he denied this, stated the allergy information was provided by hospice. Inquired of MD if he would have ordered medications such as Benadryl and an Epi pen prn (as needed) to have on hand if he knew of her allergy reaction to nuts and he confirmed this and stated these are in the e-kit (emergency kit). MD stated he believed R7 was exposed to trace amounts of nuts in the dessert she ate.</p> <p>On 04/24/25 at 03:11 PM an interview was conducted with Head Nurse RN6 in the conference room. Inquired of RN6 if allergies are included in the baseline care plan when residents are admitted . RN6 stated allergies are included in the allergy tab in resident's EHR but never put in the baseline care plan. RN6 confirmed she inputted R7's allergies into the EHR. Inquired if RN6 went over allergies and her reactions with R7 and RN6 denied this. RN6 stated they base it upon the discharge list that comes with the resident, it has a list and sometimes has information like GI upset or unknown response. Inquired about R7's care plan and RN6 stated the nut allergy was added to R7's care plan after she (R7) had the severe allergic response. Concurrent review of R7's baseline care plan revealed there is a diet section which only included R7's diet, not that the R7 has an allergy to nuts.</p> <p>On 04/24/25 at 04:45 PM an interview was done with R7 in her room at the bedside. Inquired if resident had told any facility staff about her reaction to her nut allergy. Resident explained she had met with a lady, believes she was a dietician, could not remember her name but explained she was very professional and knowledgeable and took notes down of her food preferences and resident explained her nut allergy was her most dangerous allergy. Inquired if any of the nurses inquired of her allergy reactions and resident said no. Inquired how long resident has had the allergy to nuts and she stated, since I was a baby, that her mother was afraid she would lose her because of it.</p> <p>On 04/25/25 at 09:20 AM inquired of Kitchen Manager (KM) for a copy of the Jello dessert recipe and received a copy of facility's recipe for Jello Cream Cheese Square. KM stated they use this recipe but no longer add nuts to the recipe since they have gone nut free. Review of the recipe found it contained Walnuts (minced) - 4 cups.</p> <p>On 04/25/25 at 10:09 AM an interview was conducted with the DON in the conference room. Reviewed R7's admission paperwork with DON who confirmed the nurse should have circled or wrote the reaction to R7's allergies on the admission Orders form. Inquired if nurses are expected to interview residents when they are admitted and ask what their allergy reactions are and DON stated the expectation was not to interview residents about their allergies, the facility would avoid it, for example if the resident were allergic to penicillin the resident would not get this medication. DON stated they would use the discharge summary as the communication from the hospital and enter the information into PCC (Point Click Care, electronic health record software). PCC will alert the doctor if they order a medication the resident is allergic to. Inquired who the pre-administration form is sent to, and DON stated everyone on the team.</p> <p>Review of R7's physician progress note dated and timed for 03/19/25 at 23:20 (11:20 PM) states:</p> <p>Note Text: Progress note:</p> <p>Subjective:</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>Patient was transferred from Name of Nursing Facility to Name of Acute Hospital emergency room for anaphylaxis after she inadvertently consumed nuts that were in her Jell-O pudding dessert. She had periorbital swelling, shortness of breath, and desaturation. Upon transfer by EMS personnel, patient received epinephrine and diphenhydramine IV pushes. She did receive methylprednisolone IV in the emergency department. Allergic reactions completely resolved. Patient to return back to the nursing facility.</p> <p>Objective:</p> <p>Prior to transfer to Name of Acute Hospital emergency room: Vital signs: Temperature 97.4. Pulse 87. Respiratory rate 20. Blood pressure 130/67. Oxygen saturation 94% on room air. Subsequent desaturation to 84% room air. 94% on 5 L/min via nasal cannula. General: Patient appears to be in distress. HEENT: Periorbital edema. Lungs: Diminished. Cardiovascular: Regular rate and rhythm. Abdomen: Nondistended. Bowel sounds present. Extremities: No edema. No clubbing. No cyanosis. Neurologic: Unchanged.</p> <p>Assessment:</p> <p>Anaphylaxis secondary to inadvertent consumption of nuts with her Jell-O pudding dessert. Patient has underlying history of allergies to nuts. Allergic reaction has resolved after interventions which consists of diphenhydramine, epinephrine, and methylprednisolone IV. Patient is medically stable to be transferred back to Name of Nursing Facility.</p> <p>Plan:</p> <p>Patient returning from Name of Acute Hospital emergency room back to Name of Nursing Facility. Avoid administration of nuts in which patient is allergic to.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>Based on interview and record review, the facility failed to ensure one of three residents (Resident (R) 7) sampled for food allergies, was not served a food allergy. R7 was served mayonnaise on her lunch tray, a documented anaphylactic allergy, after R7's recent anaphylactic incident regarding a nut allergy that happened in the facility. This puts R7 at risk of allergy symptoms or anaphylaxis.</p> <p>Findings Include:</p> <p>On 04/25/25, an abbreviated survey was conducted for a facility reported incident (FRI), ACTs #11581. The facility was found not in compliance with requirements of 42 CFR 483, Subpart B, F684, Quality of Care. The facility was aware of R7's nut allergy but failed to document severity of nut allergy, failed to develop and implement a care plan for R7's nut allergy and failed to assure all recipes cooked in the kitchen were on the templates reviewed for food allergies before providing food to residents. The deficient practice resulted in harm to R7 who received food that contained nuts and having an anaphylactic response requiring transport to the emergency room for treatment on 03/19/25. In response, the facility submitted the following, but not limited to, plan of correction (PoC), ADMIN [Administrator] and FSM [Food Service Manager] re-educated . staff on 03/21/24 on the importance of double checking food allergies on ticket against what they plate during tray line .Completed 05/09/25, and DON [Director of Nursing], SRNs [Nurse Supervisors], HNs [Head Nurses], and EN [Education Nurse] conducted in-services from 03/27/25 to increase awareness/re-educate nursing staff on resident food allergies, importance of double checking allergies on Gerimenu ticket against what is served on meal tray, and yellow/colored tickets when passing meal trays. Completed 05/23/25.</p> <p>On 06/05/25, during the onsite revisit for the 04/24/25 survey, review of R7's Electronic Health Record (EHR) was done. R7's nursing progress note dated 05/21/25, documented a certified nurse aide [CNA] reported R7 called to let her know she was concerned with her meal tray. R7's care plan documented on 05/21/25, R7 was served salad with mayonnaise.</p> <p>Review of R7's list of documented allergies included mayonnaise, salad dressing, mustard, nuts, and teriyaki sauce with prior anaphylactic reactions.</p> <p>On 06/05/25 at 12:10 PM, an interview with R7 was done. R7 reported she has been checking her food due to her anxiety with receiving a food she is allergic to since the nut incident and that there was an incident in May with a salad having mayonnaise in it. R7 confirmed she is allergic to mayonnaise and a kitchen staff came down to apologize and reportedly stated it was their mistake.</p> <p>On 06/05/25 at 12:56 PM, an interview with Registered Nurse (RN) 19 was done. RN19 reported CNA11 served R7's lunch on 05/21/25 and answered R7's call light when R7 reportedly had concerns with mayonnaise on her salad in her meal tray. RN19 confirmed staff serving resident meals are to check their meal ticket, especially yellow meal tickets (indicating a resident has a food allergy), prior to bringing the meal tray to the resident. On 05/21/25 during lunch, RN19 confirmed it was not done and the facility started the yellow meal tickets in March.</p> <p>Review of R7's meal ticket on 05/21/25 documented R7 has an allergy to mayonnaise and menu instruction of CUBED PLAIN TOMATO SLD [salad], NO DRSG [dressing] / MAYO [mayonnaise].</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/06/25 at 09:40 AM, an interview with FSM was done. FSM reported after R7's anaphylactic incident with nuts, the facility changed their meal tickets to yellow for residents with food allergies. FSM stated the kitchen staff are supposed to check if any food allergies made it to a resident's meal tray during tray line, but on R7's meal tray on 05/21/25 for some reason, we didn't catch that. FSM admitted the meal ticket can be confusing due to it documenting NO DRSG/ MAYO and it would be better if it documented PLAIN because it can confuse staff when looking at the meal ticket briefly.</p> <p>On 06/06/25 at 09:53 AM, an interview with DON was done. DON confirmed the nursing staff are to check the residents with yellow meal tickets prior to going to the resident's room. DON further confirmed CNA11 was trained prior to the incident and should have checked the meal ticket.</p> <p>On 06/06/25 at 10:01 AM, an interview with Registered Dietician (RD) was done. RD stated, whatever is written in the meal ticket should be followed.</p> <p>Review of the facility's policy and procedure regarding allergies effective 05/14/25 documented under section E. Food Allergies, Meal Tickets will be printed on Yellow/colored paper to alert dietary staff when plating meals, so appropriate substitution can be made. Nursing staff will check yellow / colored meal ticket against the plated food before presenting to resident. If any discrepancy - clarify with dietary before serving food to resident.</p>		