

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Nuuanu Hale		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 Pali Highway 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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47783</p> <p>Based on observations, interviews and record review, the facility failed to ensure a resident's (Resident (R)2) environment was free from accident hazards related to elopement from the facility. R2 was able to exit the facility without authorization and was found at a driveway across the street. This deficient practice has the potential to affect ambulatory residents in the facility and result in injury related to falls or car striking resident.</p> <p>Findings include:</p> <p>Review of Aspen Complaint/Incidents Tracking System (ACTS) report #1 1273 revealed that on 10/20/24, R2 was last seen in the facility at 08:45 AM by multiple staff, sitting up in her bed talking to her roommate. At 09:38 AM, R2 was found across the street from the facility walking up the driveway of another property. An investigation was conducted on how R2 was able to exit the facility without authorization. R2 was interviewed and was not able to recall how she got out of the facility. A trail of the R2's belongings were found in the courtyard area and a short rock wall leading to the driveway exit.</p> <p>On 11/06/24 at 09:47 AM, a concurrent interview and record review was conducted with the Administrator in the conference room. Administrator said that R2 was admitted to the facility for short-term rehabilitation after knee surgery. Elopement assessment was completed on her admitted and showed she was not at risk for elopement. R2 was also cognitively intact as documented in the electronic health record (EHR).</p> <p>Administrator offered a tour of the first-floor unit and courtyard area where some of R2's belongings were found. While walking through the first-floor unit, observed that the door to the staff lounge was open and there was a sliding door leading to the courtyard that was unlocked. Asked administrator if the facility secure the door leading to the staff lounge. Administrator said the staff leave the door open to let the air in from outside but they close the screen door. At the courtyard, Administrator showed where the staff found R2's belongings by the rock wall. Administrator also pointed out that the facility already completed the fence to enclose the courtyard. Asked Administrator if residents were allowed in the courtyard unsupervised. Administrator said they were not and that the residents should always be accompanied and monitored by staff while in the courtyard.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/07/24 at 08:31 AM, an interview with Registered Nurse (RN)1 was conducted at the nurse's station. Asked RN1 if the residents are able to exit the facility without letting the staff know. RN1 said the doors require a card key in order to open and only the staff have them. Asked RN1 if the sliding door at the staff lounge leading to the courtyard locked. RN1 said they only lock it at night.</p> <p>On 11/07/24 at 08:41 AM, an interview was conducted with Certified Nursing Assistant (CNA)2 at the first-floor staff lounge. Asked CNA2 if the staff close sliding door that leads to the courtyard when they are done with their break. CNA2 said they do but when sliding door was checked, it was open and only the screen door was closed. Upon closer inspection, noted the screen door did not have a latch that locked it in place. Asked CNA2 if the staff would know if anyone, including a resident, were to open the door and go to the courtyard if nobody was in the staff lounge. CNA2 said they would not know since there was not alarm for the sliding door.</p> <p>On 11/07/24 at 10:59 AM, observed door to staff lounge was open. There were no staff in the area and the sliding door was open. Screen door was closed but can be easily opened since there was no latch to keep it secured.</p> <p>Review of facility policy titled Elopement and Wandering Residents stated, . Elopement occurs when a resident leaves the premises or a safe area without authorization . and/or any necessary supervision to do so.</p> <p>On 11/07/24 at 01:26 PM, an interview was conducted with the Administrator and Director of Nursing (DON) in the conference room. Asked DON where they suspected the resident exited the building. DON said, Most likely through the staff lounge. Administrator added that is why they made sure the fence was installed immediately. When asked if they considered the courtyard a safe place for the residents to be without any supervision, both Administrator and DON acknowledged that it was not since accidents could happen there specially when the floor is wet.</p>		