

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

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2026
NAME OF PROVIDER OR SUPPLIER Samuel Mahelona Memorial Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 4800 Kawaihau Road Kapaa, HI 96746	
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 0689 Level of Harm - 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 record review and interview the facility failed to provide adequate supervision to prevent an accident for one of three residents (R) 13 sampled for accidents related to falls resulting in major injury and pain. The deficient practice puts all residents, who are at a high risk for falls, who are informally monitored on one to one for falls prevention, at great risk for a fall with injury and pain. Findings Include: On 08/06/25 at 4:49 PM the Office of Health Care Assurance received an initial report via fax from the facility reporting R13 had an unattended fall on 07/04/25 at 1:00 PM resulting in an Acute comminuted right femoral neck fracture. R13 was transferred to the hospital on [DATE] and underwent surgical repair on 07/05/25. R13 returned to the facility on [DATE] at 1015. Facility reported on 07/14/25 at 3:30 PM R13 had an unwitnessed fall from her wheelchair when she attempted to stand. X-rays were done showing Right proximal femoral endoprosthesis in place; No acute fractures identified. On 7/15/25, she visited the orthopedic office where repeat X-Rays showed Stable R Hip Hemi - L Hip no Fx Seen. Facility reported today 08/01/25 at 12:24 PM, x-rays were repeated because R13 complained of pain while up ambulating and had no demonstrated improvement. X-ray today showed Fracture of the right greater trochanter appears new since 07/14/25; Right proximal femoral endoprosthesis in place. Follow up visit at hospital x-ray done prior to visit shows no fracture. On 05/14/26 at 9:19 AM an interview was conducted with Certified Nurse Aide (CNA) 62 in the conference room. Inquired of CNA62 if she was assigned to do one to one with R13 on 07/14/25. CNA62 denied being assigned one to one with resident on 07/14/25, stated she was taking care of the residents in this section that R13 resides in, she was assigned residents that day, a case load which is about 8 residents. CNA62 confirmed that she told Registered Nurse (RN)29 that she wanted to go home and CNA62 stated she tagged (endorsed/handed over duties of one to one) RN29 who said yes and CNA62 stated so I can go home. Inquired of CNA62 what tagged meant and she stated, I can tag you which means they can stay with the resident. Inquired if R13 was on a one-to-one monitoring and CNA62 stated she was not sure if R13 was on one-to-one monitoring. CNA62 denies R13 stood up and fell while she was monitoring R13. On 05/14/26 at 9:38 AM an interview was conducted with the Director of Nursing (DON) in the conference room. Inquired of DON when R13 was placed on one-to-one monitoring and she stated on 07/09/25, when she returned to the facility after having had right hip surgery due to a previous fall on 07/04/25. DON stated on 07/04/25 R13 was positive for COVID, and she was in isolation and stood up to go to the bathroom and fell right outside of the bathroom. R13 required stand by assistance because of her advanced dementia that she would forget what needs to be done in the bathroom. At this time, on 07/04/25, DON stated R13 was a medium risk for falls. Resident had a floor alarm but because the door needed to be closed (due to COVID) the staff did not hear the alarm. Since this occurred the facility has changed its practice to leave the door open. Inquired of the DON who was assigned to do one to one monitoring with R13 and she stated CNA62 and CNA47. DON stated she believes the resident stood up from her wheelchair and tripped over the footrest and had the fall. DON stated the unit had an outbreak of COVID at this time, and the other CNAs were helping on the floor. Inquired why the CNAs assigned were helping on the (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and implement individualized dementia care plans for three of four residents (Resident (R) 4, R6, and R7) reviewed for dementia care. This deficient practice placed residents with dementia at risk for unmet needs and failure to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings Include:1) R6 is [AGE] year-old female admitted to the facility on [DATE] for long term care. Diagnoses included the following, but not limited, to high blood pressure, vascular dementia, type 2 diabetes, and motor speech disorder. Review of R6's Electronic Health Record (EHR) revealed R6 is prescribed psychotropic medications, has a diagnosis of dementia, and found no care plan related to dementia care. On 05/13/26 at 02:47 PM, an interview was conducted with Director of Nursing (DON). DON confirmed R6 did not have a care plan for dementia care. 2) R4 was admitted to the facility on [DATE] with diagnoses, but not limited to, dementia with mood disturbance, major depressive disorder, borderline personality disorder, and obstructive sleep apnea. Review of R4's EHR revealed R4 is prescribed psychotropic medications, has a diagnosis of dementia, and found no care plan related to dementia care. On 05/13/26 at 01:47 PM, an interview was conducted with DON. DON confirmed R4 did not have a care plan for dementia care. 3) On 05/12/26 at 03:45 PM, record review of R7's EHR found his diagnoses include, but are not limited to, peripheral neuropathy, atrial fibrillation and chronic constant pain due to injury. Review of R7's Center of Medicare and Medicaid Services Minimum Data Set (MDS) with an Assessment Reference Date (ARD) observation end date of 04/28/2026 found resident was coded as having an active diagnosis of non-Alzheimer's dementia. On 05/13/26 at 08:00 AM, requested a printed copy of R7's dementia care plan from the DON. On 05/13/26 at 11:13 AM, an interview was conducted with the DON in the conference room. DON was able to provide copies of some of R7's care plans. DON stated R7 did not have a CP for resident's dementia care. Inquired if this should have been included in R7's CP and DON confirmed this should have been included. Requested a copy of the facility's policy on care planning which she was able to provide. On 05/13/26, review of facility policy titled Behavior Management Program with an effective date of November 14, 2025, states, I. Purpose: To define and set expectations for the provision of mood, behavioral health, and dementia care services to ensure each resident attains and maintains their highest practicable physical, mental, and psychological well-being. This includes residents with dementia, severe mental illness, intellectual disability, or related conditions.IV. Procedure: D. Person-Centered Care Plan 1. The IDT will develop a comprehensive care plan including: a. Mood and behavior interventions b. Dementia-specific approaches c. Environmental modifications d. Non-pharmacological interventions.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to store and label food, and failed to ensure the ice machine in the kitchen was kept in clean and sanitary condition, in accordance with professional standards for food service safety. This deficient practice puts residents at risk for serious complications from foodborne illness as a result of their compromised health status. Unsanitary food handling and/or equipment maintenance practices represent a potential source of pathogen exposure for all residents at the facility. Findings Include: On 05/11/26 at 08:29 AM, during initial tour of the facility's kitchen, concurrent observation and interview were done with the Hospital Executive Chef (HEC). Observed large plastic container with expired uncooked rice with a use-by label date of 04/07/26. Multiple food items stored in the walk-in freezer observed as expired and without proper labels. HEC was queried if containers should be labeled correctly after food was transferred from the original containers and expired foods should be discarded, HEC confirmed and agreed that all food containers should be properly labeled and all expired food discarded. On 05/11/26 at 08:37 AM, continued concurrent observation and interview of facility's kitchen with HEC. Observed a buildup of hardened brown sediment/material around the bottom edge and side panel of ice machine in the kitchen. HEC explained that an outside vendor, [NAME] Refrigeration Kauai (RRK), is responsible for doing preventive maintenance (PM) and cleaning of the ice machine. RRK was scheduled to perform PM and cleaning of the ice machine in February 2026 but had to reschedule for 05/11/26 due to staffing issues. EC also agreed that the ice machine should be cleaned regularly to maintain and prevent buildup of brown sediment/material on any part of the ice machine. The kitchen ice machine quarterly PM log indicated that PM was only done on 08/12/25 and 11/17/25, but no PM was done for 2026. Reviewed facility's policy and procedure titled, Food Preparation and Storage with an effective date of 03/02/26. The policy instructs staff to make sure that .Items will be labeled with the date and food service employee number.3. All chilled food items.will be disposed within expiration.all frozen food items.will be disposed within expiration. Policy and procedure titled, Storage and Handling of Ice with an effective date of 06/14/25 stated, .D. Preventive Maintenance (PM) Ice Machine.1. PM will be done quarterly and as needed.		

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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. Based on record review and interview, the facility failed to ensure a resident or resident representative was informed of treatment and provided consent for the use of psychotropic medication for one of five residents (Resident (R) 40) reviewed for unnecessary medications. This failure placed R40 at risk for receiving treatment without informed consent and compromised the resident's rights to participate in care planning and treatment decisions. Findings Include: Review of R40's physician orders revealed the resident was prescribed trazodone, an antidepressant medication, 50 milligrams (mg) every morning beginning on 11/10/25. Review of R40's Electronic Health Record (EHR) revealed no documented informed consent for trazodone 50mg prior to administration of the medication. On 05/13/26 at 02:01 PM, an interview was conducted with the Director of Nursing (DON), who confirmed the facility did not obtain consent for the administration of trazodone 50mg.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the discharge/transfer form used by the facility was provided to the resident, resident's representative, and Ombudsman for one of three sampled residents (Resident (R)49). Findings include: On 05/12/26 at 01:36 PM, review of R49's Electronic Health Record (EHR) documented the resident was transferred and discharged to the hospital on [DATE] at 11:39 AM. Unable to locate a written discharge/transfer notification to the resident/resident representative or Ombudsman. Request a copy of the written transfer/discharge notification from the Director of Nursing (DON). On 05/13/26 at 02:28 PM, conducted an interview with the DON. DON confirmed a written notification was not provided to the resident, resident representative, and Ombudsman. Review of the facility's policy and procedure titled, Resident Transfer and Discharge with an effective date of 07/22/25, states that, .D. 1. Notice of discharge shall be provided to the resident and the resident's representative. 2. A copy of the notice shall also be provided to the Hawaii LTC Ombudsman at least 30 days prior to the discharge.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations and interviews, the facility failed to ensure one of three treatment carts and one of three medication carts were locked when unattended by nursing staff. This deficient practice allowed unauthorized access to medications and treatment supplies, placing medications at risk for diversion and placing residents at risk for not receiving medications and dressing changes as prescribed. Findings Include: 1) On 05/13/26 at 08:34 AM, during medication administration observation, observed the treatment cart with prescribed topical medications and other supplies for the residents in the hallway unlocked and unsecured. Registered Nurse (RN) 24 was asked if medication cart should be locked when not in use, or before leaving treatment cart to administer medication to residents, RN24 confirmed that it should be locked and secured. RN24 stated that she forgot to lock the cart after grabbing band aid to apply to a resident's wound. On 05/13/26 at 09:20 AM, an interview was conducted with the Director of Nursing (DON). Shared observation of the unlocked treatment cart with DON and DON confirmed that treatment carts should always be locked and secured when not in use. 2) On 05/13/26 at 11:28 AM, observed a medication cart in the hallway near a resident's room unlocked and no nurses nearby. Licensed Practical Nurse (LPN) 4 came out of the resident's room. LPN4 noticed the medication cart was unlocked and stated she got distracted by the resident who had yelled out for help and she went to help him. Inquired if the medication cart is to be locked before the nurse leaves the cart and LPN4 confirmed she is to lock the medication cart before leaving it. On 05/14/26 requested, received and reviewed facility policy on Medication Storage with an effective date of March 15, 2026, stated, I. Purpose: To ensure all medications and biologicals are stored, secured, handled, and maintained in accordance with Centers for Medicare and Medicaid Services (CMS) Requirements of Participation, state regulations, Drug Enforcement Agency (DEA) requirements, and accepted professional standards of practice. To provide guidelines that support resident safety, prevent medication diversion, and preserve medication integrity. III Policy: . B. Medications will be stored in a manner that prevents contamination, deterioration, and unauthorized access. D. Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended by persons with authorized access.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview, the facility failed to provide education for five of five residents (Resident (R) 1, R3, R4, R7 and R13) or their representative, reviewed for influenza immunizations, regarding the risks and benefits and potential side effects of influenza immunization before offering the influenza immunization and obtaining consent or declination from the resident or their representative. This deficient practice puts all residents at risk of not being fully informed about their risks and benefits and potential side effects of receiving or declining the influenza immunization. Findings Include: On 05/12/26 at 02:53 PM, record review was conducted for R1, R3, R4, R7 and R13 to assure each resident received or declined their annual influenza vaccination for 2025. The facility was able to provide copies of these residents' consent/declination forms. Review of R1's form found it was dated 09/28/25 and consent was given for the influenza vaccination. Review of this form found the facility staff had circled N (No) for I was provided with education and the CDC Vaccination Information Statement (VIS) (if available) about the benefits, risks and potential side effects associated with the vaccine. Review of R3's consent/declination form which was dated 10/27/25 and consent given to be vaccinated for influenza vaccination. Review of this form found the facility staff had circled N (No) for I was provided with education and the CDC Vaccination Information Statement (VIS) (if available) about the benefits, risks and potential side effects associated with the vaccine. Review of R4's consent/declination form which was dated 10/04/25 and consent given to be vaccinated for influenza vaccination. Review of this form found the facility staff had circled N (No) for I was provided with education and the CDC Vaccination Information Statement (VIS) (if available) about the benefits, risks and potential side effects associated with the vaccine. Review of R7's consent/declination form which was dated 10/27/25 and consent given to be vaccinated for influenza vaccination. Review of this form found the facility staff had circled N (No) for I was provided with education and the CDC Vaccination Information Statement (VIS) (if available) about the benefits, risks and potential side effects associated with the vaccine. Review of R13's consent/declination form which was dated 09/25/25 and declination signed not to be vaccinated for influenza vaccination. Review of this form found the facility staff had circled N (No) for I was provided with education and the CDC Vaccination Information Statement (VIS) (if available) about the benefits, risks and potential side effects associated with the vaccine. On 05/14/26 at 11:17 AM, an interview was conducted with the Infection Preventionist (IP) in the conference room. Inquired of IP why facility staff were putting N (no) for no education given to the resident/representative prior to getting consent or declination for the influenza vaccination. IP stated she tracks the dates of the vaccines for all residents but was not aware the nurses were doing this. IP nurse confirmed the resident, or their representative, is to be given the education/CDC Vaccination Information Statement (VIS) prior to acquiring consent or declination for the influenza vaccination and confirmed this information is in the facility policy.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview the facility failed to provide education for one of five residents (Resident (R) 1) or their representative, reviewed for COVID-19 vaccine, regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine before offering the vaccine and obtaining consent or declination from the resident or their representative. This deficient practice puts all residents at risk of not being fully informed about the benefits and risks and potential side effects associated with the COVID-19 vaccine administered at the facility. Findings Include: On 05/12/26 at 02:53 PM, record review was conducted for R1 to assure the resident received or declined their COVID-19 vaccine. The facility was able to provide a copy of R1's consent/declination form. Review of R1's consent/declination form found it was dated 09/28/25 and consent was given for the COVID-19 vaccination. Review of this form found the facility staff had circled N (No) for I was provided with education and the CDC Vaccination Information Statement (VIS) (if available) about the benefits, risks and potential side effects associated with the vaccine. On 05/14/26 at 11:17 AM, an interview was conducted with the Infection Preventionist (IP) in the conference room. Inquired of IP why facility staff were putting N (no) for no education given to the resident/representative prior to getting consent or declination for the COVID-19 vaccine. IP stated she tracks the dates of the vaccines but was not aware the nurses were doing this. IP nurse confirmed the resident, or their representative is to be given the education/CDC sheet and confirmed this is in their facility policy.		