STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125032	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hale Ho'Ola Hamakua	45-547 Plumeria Street Honokaa, HI 96727

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 0600 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22063 Based on observations, record reviews, and interview, the facility failed to protect a resident (Resident 310) from physical abuse. The facility did not de-escalate the situation between two roommates, resulting in Resident (R)50 going over and punching R310. This deficient practice has the potential to affect the residents' optimal physical and psychosocial well-being. Findings include: On 06/17/24, the facility submitted an Event Report regarding an allegation of abuse, resident to resident. On 05/18/24 at approximately 02:50 AM, Resident (R)310 alleged he was punched by his roommate, R50. The report documents at approximately 02:00 AM, Certified Nurse Aide (CNA)1 heard the residents yelling. R310 reportedly turned on the television and had the volume turned up, waking his roommate. R50 was heard telling R310 to go to sleep and turn off the television. Registered Nurse (RN)1 provided R310 with headphones to connect to his TV. After this, Licensed Practical Nurse (LPN)1 heard the television playing loudly again and entered the room to ask R310 why he wasn't using the headphones. R310 responded he could not hear the TV with the headphones on. Later R50 was again heard yelling for his roommate to go to sleep. LPN1 entered the room again and instructed R310 to use the headphones, but he did not. Shortly after that, LPN1 heard yelling from the room, He punched me! Upon entering the room, LPN1 saw R50 standing by R310's bed. Upon immediate assessment, RN1 found a small abrasion to R310's chin with minimal bleeding, and first aid was provided. R310 complained of pain to his jaw, a 9/10 upon pressing. R310 was provided with Tylenol and an ice pack. The facility documented in March 2024, R50 had a previous incident of punching and kicking a male CNA after accusing the staff member of being gay. The facility further indicated R50 becomes agitated when residents yell out and also had a conflict with a different roommate regarding his television being too loud, however, there had been no history of physical altercations. The facility developed interventions to address R50's agitation when other residents talk loudly, redirect me to where it is quiet and calm and do 15-minute checks. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 11/19/24 at 11:46 AM, R50 was walking in the hall with staff, he was observed to constantly make verbal sounds. Subsequent observations saw staff members going in and out of resident's room. R50 refused lunch. On 11/21/24 at 08:47 AM, R50 was observed lying in bed, bed at lowest setting, and appeared to be asleep. On 11/21/24 at 12:16 PM, R50 observed in dining room waiting for lunch, dozing off in chair at table, seated next to female resident, and no yelling or behavior observed or overheard. At 12:24 PM, R50 was awake, and was moved next to a male resident. R50 was observed to display impulsivity and impatience, yelling out unintelligibly and looking around to get staff attention. Subsequent observation at 12:27 PM found R50 walking back to his room with a staff member. At 12:39 PM, three staff members were observed in the room with the resident, encouraging him to eat his lunch. One staff member remained behind to assist R50 with lunch, it was quiet, and the staff member was gentle and treated resident with respect and dignity. On the morning of 11/21/24 a record review was done. The alleged perpetrator, R50 was admitted to the facility from an acute hospital on 01/22/24 with diagnoses including dementia; schizoaffective disorder, behavior problem; and Alzheimer's disease. A review of his medication orders included buspirone, 5 mg twice a day (anxiolytic sedation); Lexapro, 20 mg daily (antidepressant); risperidone, 3 mg twice a day (antipsychotic); and trazodone 75 mg (antidepressant). A review of the Medication Administration Record (MAR) for the use of psychotropic medications identified the following behaviors related to the use of medication: trazodone and melatonin for sleeping; risperidone for auditory hallucinations, standing on bed, and talking to self and others; Lexapro for combative behavior, irritability and refusal of care; and buspirone for restlessness. A review of his admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 01/29/24 notes R50 is cognitively impaired. R50 requires supervision for sit-to-stand and is able to walk 10 feet with supervision or touching assistance. There were no noted behaviors documented. Immediately following the May 2024 incident, R50 was moved to a single room and care plan revision was done on 05/18/24. Revised interventions included: providing visual supervision at all times when out of his room due to history of altercation with other residents who are loud and please redirect me to where it is quiet and calm. A review of the alleged victim's record was also done. R310 was admitted to the facility on [DATE] and discharged on [DATE]. A review of the admission MDS with ARD of 05/17/24 noted R310 is cognitively intact. The social worker's note (dated: 05/21/24 at 11:02 AM) regarding R310's altercation with R50 noted R310 reported R50 became irritated because his television was too loud. R50 reportedly came over to grab the remote control, when R310 attempted to stop him, R50 punched him. R310 reportedly had pain to his jaw and informed the social worker that he feels safe in the facility and denied any concerns of anxiety. A review of the facility's policy and procedure, Freedom from Abuse/Neglect/Exploitation Long Term Care Residents was done. The definition of resident-to-resident abuse includes: A. Cognitive impairment or mental disorder does not preclude a resident from being abusive. B. In determining abuse, willful (deliberate) action (not inadvertent or accidental) will be considered regardless of whether the individual intended to inflict injury or harm . The definition of physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/25/24 a telephone interview was conducted with the Director of Nursing (DON). DON reported that she led the investigation for the abuse allegation and confirmed that abuse had occurred. DON reported R50 was physically able to get out of bed and walk over to R310's bed. R50 could also stand on his bed and squat down and up. DON reported R50 becomes agitated when other residents yell out or become disruptive. Inquired how does R50 express agitation? DON provided the following example: in the past R50 would become agitated by a former resident and there was an incident of R50 approaching the resident and appeared to make gestures to hit him. Staff members were able to prevent an altercation between the residents at that time. DON reported staff members keep constant watch of R50 when he is out of his room; he is escorted to the dining room and wherever else he goes. R50 also reportedly stays in his room alone, watching football. R50's room is close to the facility's nursing station to provide continuous monitoring of the resident. The observations, record reviews and interview, found the facility met the criteria of past noncompliance: at the time of the incident, the facility was not in compliance with the regulatory requirements; the noncompliance occurred after the exit date of the last standard survey (12/08/23) and before the current recertification survey; and there was sufficient evidence that the facility corrected the noncompliance, the facility revised and observations during the current survey confirmed, staff members were implementing R50's plan of care. To date, the interventions are effective, as evidenced by no subsequent incidents or allegations. The facility continues to monitor R50's behaviors (sleeplessness, auditory hallucinations, standing on bed, talking to self and others, restlessness, combative behavior, irritability, and refusal of care) as it relates to the use of psychotropic medication. The facility communicates R50's care plan revisions to staff via huddles and communication report. The facility also provided an in-service to all staff on 05/21/24 regarding the facility's policy and procedures for abuse and neglect.

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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** 39754 Based on record review, staff interview, and policy review, the facility failed to monitor vital signs; blood pressure for one Resident (R) 57 of fourteen residents sampled. As a result of this deficiency, the facility put R57 at risk for further health complications. Findings include: Review of Electronic Health Record (EHR), on 11/21/24 at 08:25 AM, showed R57 admitted on [DATE] with diagnosis including recent Hip Fracture, Chronic Kidney Disease, Lymphedema, Paroxysmal Atrial Fibrillation, Hypertension, High Cholesterol, Venous Stasis. There was an active doctor order to take vital signs; blood pressure routine (monthly for this resident). Blood pressures were documented on the following dates: 11/12/24, 09/26/24, 09/13/24. During staff interview on 11/21/24 at 09:20 AM, Director of Nursing acknowledged that vital signs; blood pressures were not taken monthly as ordered. On 11/21/24 at 10:45 AM, review of policy for Extended Care Facility Vital Signs read Purpose, to assist in assessing resident's physiological parameters, early detection of disease process. Policy, Vital signs include temperature, pulse, respirations and blood pressure. Vital signs will be taken on all residents upon admission to Extended Care Facility. Thereafter, vital signs shall be taken as ordered by the physician, or as follows . Vital signs weekly on all skilled nursing facility patients and monthly for all intermediate care facility patients .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to ensure 1 of 14 residents sampled (Resident 11) was free from accident hazards. Resident 11 was transferred using a mechanical lift transfer in a manner that placed her at risk for an avoidable fall and/or injury. This deficient practice has the potential to affect all the residents at the facility who are dependent on mechanical lift transfers. Findings include: Resident (R)11 is an [AGE] year-old female admitted to the facility on [DATE]. On 11/19/24 at 12:02 PM, observations were made at the bedside of R11. Certified Nurse Aide (CNA)2 and CNA3 were transferring R11 from her bed to a standard wheelchair via a mechanical lift. Observed CNA3 positioned behind the wheelchair, tilting it up onto its back two wheels, leaving the front two wheels approximately a foot off the ground, while CNA2 operated the mechanical lift, lowering R11 into the tilted wheelchair. Interviewed both CNAs at the bedside as soon as the wheelchair with R11 in it had been lowered safely back down with all four wheels on the ground. CNA3 stated that they needed to tilt the wheelchair to lower R11 into it because she had a standard wheelchair that could not have the back lowered. Since R11 hung in a semi-reclined position on the mechanical lift, they felt they needed to ensure the wheelchair was in a semi-reclined position to receive her. On 11/21/24, a review of R11's comprehensive care plan (CP) for Potential for Decrease in ADL [Activities of Daily Living] noted that on 05/25/24, per PT [physical therapy] recommendation, . [mechanical] lift transfers . On 11/21/24 at 09:06 AM, an interview was done with the Assistant Administrator, who also served as the Regional Director of Nursing and the facility Infection Preventionist (IPC), in her office. When the observation was described to IPC, she agreed that it was not a safe transfer, either for the staff or the resident. IPC also agreed that she would have expected the CNAs to pull the sling of the mechanical lift to re-position the resident into the position required to lower her into the wheelchair, not the other way around. On 11/21/24 at 09:50 AM, a review of the Kwikpoint Patient Lifts Safety Guide, provided by the facility as training materials, noted that on page eleven (11), Lower the Patient instructs the mechanical lift user(s) to Slowly lower patient toward receiving surface. Move patient's body into correct position on receiving surface before releasing patient's weight. The Safety Guide includes an illustration where the staff member is repositioning a patient in the mechanical lift sling into an upright position as patient is being lowered into a standard wheelchair.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39754 Based on observation and staff interview, the facility failed to record hot water temperatures for manual washing of dishes/pots/pans and failed to completely record hot water temperatures for the dishwashing machine. Findings include: During observation of the kitchen on 11/19/24 at 10:25 AM, there were two different dishwashing sections; manual washing and dishwashing with machine. Review of hot water temperature logs showed no recording log for the manual washing, and missing temperature logs for the dishwashing machine. During staff interview on 11/21/24 at 08:20 AM, Kitchen Staff 1 revealed that the facility did not have temperature logs for manual washing and acknowledged that there were missing temperature logs for the dishwashing machine. The facility did not provide a related policy but said that they follow Hazard Analysis Critical Control Points (HACCP) which states temperature test logs should be maintained for each hot water sanitation dishwasher in the facility in order to follow HACCP-based record keeping standards.

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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. 22063 Based on record review and interview with staff members, the facility failed to provide education regarding the benefits, risks, and potential side effects associated with COVID-19 immunization before offering the vaccine to staff member(s). Findings include: On 11/21/24 at 11:30 AM an interview was conducted with the Infection Preventionist (IPC). IPC reported the facility offered staff members the COVID-19 vaccination in October. A staff member, Kitchen Staff (KS)1 was randomly selected to verify the requirements for education and offering of COVID-19 immunization. IPC reviewed the spread sheet and reported the immunization was refused. Further queried if KS1 was provided with education on risks and benefits of the immunization. IPC reported the facility will provide a Vaccine Information Sheet (VIS) which includes education when vaccines are offered and administered, however, as the COVID-19 immunization is no longer required for staff members, the facility had not been providing the VIS. On 11/21/24 at 12:15 PM, KS1 was interviewed in the kitchen. KS1 was not sure whether the facility offered the COVID-19 immunization. KS1 reported not opting for the most recent COVID-19 immunization. At 12:22 PM, KS1 came to the conference room and reported the COVID-19 immunization was offered and she did not take it. KS1 confirmed that she was not provided with education, risks, and benefits of the COVID-19 immunization.