STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pu'Uwai 'o Makaha	84-390 Jade Street Waianae, HI 96792

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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 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** Based on observations, interview and record review, the facility failed to ensure call system equipment was within reach for one of one resident (Resident (R)2) sampled. The deficient practice placed R2 at risk of not having emergent needs met in a timely manner and has the potential to affect all residents that rely on staff for assistance with activities of daily living.Findings include: R2 was a [AGE] year-old resident admitted to the facility on [DATE] for long term care placement. Diagnoses included but not limited to quadriplegia (partial or complete paralysis of all four limbs), panic disorder and depression. BIMS (Basic Interview for Mental Status) score on 06/02/25 was 15, indicating that R2 is cognitively intact. On 07/22/25 at 12:04 PM, observed R2 lying in bed with head elevated. R2 had just finished eating lunch and was assisted by staff. The touch pad call light was on the floor and out of R2's reach. Returned to R2's room two separate occasions on 07/22/25 at 01:43 PM and 03:22 PM. Touch pad call light was observed on the floor and out of R2's reach for both times. On 07/23/25 at 03:32 PM, observed R2 lying in bed watching television. Touch pad call light was on the floor and out of R2's reach. Certified Nurse Aide (CNA)6 was in the hallway at that time and was asked if R2 was capable of using the touch pad call light. CNA6 said R2 was capable of using the call light since he was still able to move his upper extremities. Showed CNA6 the touch pad call light was currently on the floor. CNA6 acknowledged that it was out of reach and should always be placed on the bed close to R2's arms. Review of R2's care plan was conducted. Under Problem Category: Falls, intervention included I will recognize need for assistance and ask for help as needed, call (pad)bell in reach. Start dates for both problem and intervention was 11/13/24.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to maintain the activities of daily living (ADLs), specifically personal and oral hygiene, for 1 of 1 resident sampled for ADLs. As a result of this deficient practice, Resident (R)41 was hindered from attaining his highest practicable well-being and placed at risk for a decreased quality of life. Findings include:Resident (R)41 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. R41's diagnoses include, but are not limited to, Guillain-Barre syndrome (neurological disorder where the immune system mistakenly attacks the body's peripheral nerves which can lead to muscle weakness, tingling, and in severe cases, paralysis) and quadriplegia (a condition characterized by the partial or complete paralysis of all four limbs and the torso), with a colostomy (surgery that creates an opening for the colon through the belly, allowing stool to collect in a bag or pouch attached to the opening) and a gastrostomy (surgery that creates an external opening into the stomach for nutritional support). Review of R41's electronic health record (EHR) noted that on his most recent Minimum Data Set (MDS) Quarterly Assessment with an Assessment Reference Date (ARD) of 05/26/25, R41 was documented as completely dependent on staff for oral hygiene, bathing, toileting, dressing, personal hygiene, and mobility. On 07/22/25 at 09:58 AM, observations were done of R41 at his bedside. Certified Nurse Aide (CNA)2 and CNA3 were preparing to change his adult incontinence brief (brief). R41 was observed to have extremely dry and cracked lips, dry and flaky skin to his forehead, and thick, dried, yellowish crust to the inner corners of both eyes. At 10:04 AM, observed CNA2 wipe R41's right cheek and right eye, but his forehead, left eye, and left side of his face (where CNA3 was) remained unwiped. Asked CNA2 and CNA3 if they were conducting perineal (area of the body between the groin and the tailbone) care or a bed bath, to which they both answered that they were doing a bed bath. Observed them (CNA2 and CNA3) perform perineal care, wipe down R41's back and chest, and change his brief, gown, and bed linen. When they were about to place R41's bed wedge pillows (used to position, support, and/or elevate the upper and lower body) under him, asked CNA2 and CNA3 if they were done with his bed bath, hygiene, and grooming, to which they both answered yes. Reminded them that they had neglected to wipe down R41's legs and feet, his forehead, or the left side of his face, and did not perform oral care, or brush his hair (which remained disheveled). Asked if a bed bath would normally include these things, to which CNA2 responded yes, it should. At 10:26 AM, CNA2 prepared to perform oral care but found there were not enough supplies in the room to do so. Asked CNA2 and CNA3 how often oral care is performed on residents who are completely dependent on staff for hygiene. CNA2 answered that she was helping out in R41's area today, but in the area she normally works, oral care is done on every shift. While CNA3 answered that to her knowledge, oral care is only done every morning. Looking at the status of R41's lips, CNA2 agreed that it appeared as if oral care was not being done for R41 every shift, or even every day. CNA2 also acknowledged that since R41 received his nutrition and fluids through a gastric tube and nothing by mouth, regular oral care was even more important. CNA3 left the room to obtain supplies for oral care. While she was gone, CNA2 wiped the left side of R41's face and his left eye. CNA2 agreed that from the amount of dried crust on his left eye, it appeared that R41's eyes had not been wiped in more than one day. When CNA3 returned with supplies, CNA2 performed oral care. As she repeatedly and carefully wiped R41's lips with an oral swab, his dry and cracked lip skin peeled off in large chunks. Review of R41's comprehensive care plan revealed that despite identifying him as dependent on staff for all activities of daily living, including hygiene, grooming, and oral care, no specifics were planned regarding how often oral care should be performed. On 07/24/25 at 03:25 PM, an interview was done with Resident Care Manager (RCM)1 in her office. When asked how often oral care should be done for residents completely dependent on staff for ADLs, RCM1 answered that her expectation is that CNAs should be performing oral care twice a day at a minimum, on day shift and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evening shift. RCM1 agreed that a bed bath should include cleansing of the face, legs, and feet, oral care, and grooming.Review of the facility's Activities of Daily Living policy, effective date 05/01/21, noted the following: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 of 6 residents (Resident (R)52) sampled for limited range of motion (ROM) received the appropriate treatment, equipment, and/or services to increase or prevent further decrease in his mobility. As a result of this deficient practice, R52 was placed at risk of worsening contractures and hindered from reaching his highest practicable well-being. Findings include:Resident (R)52 is a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses include, but are not limited to, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting his left side following a stroke, past fracture of the neck of his right femur (top of thigh bone/hip), and contractures (a shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of his left knee and left ankle. Review of his most recent Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/11/25, noted a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating he had been determined to be cognitively intact. On 07/22/25 at 10:48 AM, observations were made of R52 at the bedside as his adult incontinence brief (brief) was being changed. R52 appeared to have a severely contracted left wrist and fingers, a contracted left knee, a contracted left ankle that was mildly twisted, and as Certified Nurse Aide (CNA)3 lifted his left arm to change his gown, his left elbow and left shoulder appeared stiff and contracted as well. None of these joints could be straightened without, or even with, assistance. There were no splints, braces, or orthotic devices of any kind visible on or near R52, or at his bedside. On 07/22/25 at 12:34 PM, an interview was done with CNA3 as she delivered R52's lunch tray. CNA3 confirmed that she was familiar with R52's care, and when asked if he had any splints or braces for his left hand, arm, or leg, she answered that she believed he did but did not know where any of them were. Observed CNA3 check his bedside table, and she confirmed there were no orthotic devices there. CNA3 also confirmed that she had not applied, removed, or seen R52 with any splints or braces on for a while. When asked if he had any splints, R52 stated that he used to have one for his left lower leg but not anymore. On 07/22/25 at 02:41 PM, during a bedside interview with R52, he stated that it had been a long while since he had received any therapy or rehabilitation services for his limited range of motion.On 07/25/25 at 09:30 AM, an interview was done with Physical Therapist (PT)1 who confirmed that she was familiar with R52. When asked if he should be wearing any orthotic devices, PT1 confirmed that R52 should be wearing splints daily on his left arm and left leg. PT1 also stated that the CNAs should be offering to apply R52's splints daily and documenting the application (or his refusal) in his electronic health record (EHR). Review of R52's Comprehensive Care Plan (CP) revealed the following planned interventions: Apply left knee and ankle splints for up to 4 hours in am [morning] and pm [evening] shift. Apply left wrist/hand splint for up to 4 hours in am and pm shifts. neck stretching towards the right, 6 second hold x [for] 5-10 reps [repetitions] per shift. perform BUE [both arms] and BLE [both legs] AAROM [active assisted range of motion]/PROM [passive range of motion] exercises every shift. Perform left elbow, wrist, knee and ankle stretching exercises every shift.On 07/25/25 at 09:53 AM, interviews were done with CNA4 and R52 at his bedside. When asked about R52's splints, CNA4 stated they were kept in a large box on the floor above his bed and that they should be applied daily. When asked to retrieve the splints from the box, observed CNA4 dig into the bottom of the box, full of various items, to get them. CNA4 agreed that if the splints were being applied as they should, they should not be at the bottom of the filled box. When asked if he wears the splints every day, R52 answered, not every day. After being asked when the last time was that he wore them, R52 responded it's been a long time. On 07/25/25 at 10:20 AM, another interview was done with R52. When asked about ROM exercises, R52 stated that no one had done ROM of his arms, legs, or done his neck stretching exercises in a very long while. When they first started doing (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that [assisted range of motion exercises], it went on for about a week, and it felt really good, but that all stopped long ago, I would love it if they would do that [again]. On 07/25/25 at 10:38 AM, concurrent interview and review of documentation of R52's splint application and ROM exercises was done with the Director of Nursing (DON). DON agreed that with a BIMS of 13, R52 would be able to remember if his ROM exercises were done or if his splints were applied. After reviewing the documentation for the last 30 days, DON could not explain why AAROM and neck stretching was consistently documented as done when the resident stated it was not, or why his splints were documented as applied 4 times in the last 5 days when R52 reported they had not been applied in a long time. DON agreed that ROM/stretching exercises and a consistently applied splinting program would be beneficial for R52 and increase his quality of life.Review of the facility's policy and procedure, Range of Motion Exercises, effective date 06/19/23, revealed the following Purpose[s] for performing ROM: To improve or maintain joint mobility and muscle strength. prevent contractures. reduce pain. prevent complications of immobility.

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F 0697 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and record review, the facility failed to prevent and manage pain adequately for 1 of 2 residents (Resident (R)8) sampled for pain. Specifically, the facility failed to ensure that R8's narcotic pain medication remained available and in stock for her as needed use and failed to offer her any non-pharmacological interventions in its absence. As a result of this deficient practice, R8 was prevented from attaining or maintaining her highest practicable level of well-being. Findings include:Resident (R)8 is a [AGE] year-old female admitted to the facility on [DATE] for long term care. Her diagnoses include, but are not limited to, polyarthritis (a condition characterized by inflammation, pain, and stiffness in five or more joints simultaneously), acquired (surgical) absence of left leg below knee, chronic post-traumatic stress disorder, and generalized muscle weakness. Review of her most recent Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/09/25, noted a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating she had been determined to be cognitively intact. On 07/23/25 at 09:41 AM, an interview was done with R8 at her bedside. R8 reported that she normally has breakfast in her room, then likes to go out to the activity room until after lunch, but that she did not feel up to it today. When asked why, R8 stated that she was experiencing pain in her back, her left shoulder, the back of neck, her right knee, and all of her fingers, and rated her pain level as a 9 out of 10. When asked what she usually takes for her pain, R8 responded that she usually takes Norco (a narcotic containing hydrocodone and acetaminophen), which manages her pain well, but it's been out for a couple days. R8 went on to explain that she also has an acetaminophen order, but it does not help her pain, so she does not ask for it. When asked about non-pharmacological interventions, R8 stated that since her Norco has been out, staff have not offered her anything besides acetaminophen (such as a hot pack or a cold pack, massage, or exercises). R8 also stated that she was not receiving physical therapy but was interested in that to help decrease her pain and increase her mobility. R8 explained that the pain is distracting and causes her to move even slower than she normally does. On 07/24/25 at 09:49 AM, an interview was done with Registered Nurse (RN)2, who confirmed that R8's Norco had been out of stock at least all week. Review of R8's provider orders noted the following physician order: Hydrocodone-acetaminophen (Norco) 5-325 mg (milligram) 1 tablet by mouth every 4 hours as needed for moderate to severe pain (6-10). The order started on 04/07/25 and had no end date. Review of R8's Medication Administration Record (MAR) noted that she was last documented as taking the Norco on 07/21/25 at 01:15 PM. Review of R8's care plan for pain revealed the following planned interventions: Administer medications as ordered. Use non-medicated pain relief measures. application of heat/cold, massage, physical therapy, stretching and strengthening exercises, etc.On 07/24/25 at 02:46 PM, an interview was done with the Director of Nursing (DON) in his office. When asked how far in advance a pain medication should be refilled, DON responded that the expectation is that when 2 days' worth remains, the nurse should initiate a refill to ensure that the medication does not run out. Concurrent review and reconciliation of R8's June/July MARs and her Norco Controlled Drug Records with DON confirmed that R8's Norco had been completely out of stock from 06/11/25 to 06/14/25 and then again from the afternoon of 07/21/25 until the afternoon of 07/24/25. DON expressed surprise that R8's Norco ran out and agreed that it shouldn't have. DON stated that he does expect nurses to offer non-pharmacological interventions especially when the primary intervention is unavailable, and agreed that part of pain management is ensuring medications do not run out. On 07/25/25 at 09:20 AM, an interview was done with R8 in the dining room, where she was smiling and reported that she felt really good and much better now that the Norco was back in stock. R8 went on to share that she had been feeling unwell and extra tired the previous two days, not wanting to move around and participate in activities, and attributed that to being in pain and not having her Norco. Review of the facility's policy and procedure, Pain Management, effective date 02/27/25, revealed (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following: In order to help a resident attain or maintain his/her highest practicable level of. well-being. the facility will. Manage or prevent pain, consistent with the. plan of care. Facility staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include. decreased participation in usual physical and/or social activities. Decline in activity level.

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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, interviews, and record review, the facility failed to ensure that medications in two of two medication carts were stored and locked in accordance with professional standards. Proper storage of medications and locking of the medication cabinet is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility who take medications.Findings include: 1) On 07/25/25 at 07:40 AM, Team 1 medication cart was inspected with Licensed Practical Nurse (LPN)10 present. Two expired medications for Resident (R)1 were found: · Genteal Tears Severe 3-94% ointment was observed with an open date of 05/04/25 and discard date of 07/04/25 written on a facility label attached to the ointment tube. Upon review of the Electronic Health Record (EHR), a readmission date of 06/05/25 for R1 was found with no readmission order for this medication. · Novolog U-100 Insulin vial was observed with an open date of 06/06/25 and discard date of 07/04/25 written on a facility label attached to the vial. Upon review of the EHR, this was an active order being administered per sliding scale subcutaneously (under the skin) five times a day. On 07/25/25 at 08:00 AM, LPN10 stated all expired or discontinued medications should be removed from the medication cart. On 07/25/25 at 11:25 AM, interviewed Resident Care Manager (RCM)1 in her office. RCM1 stated the expectation is that medications should be removed from the medication cart once discontinuation orders are obtained or if they are expired. RCM1 also stated that insulin medication has a 28-day expiration once opened and thinks that eye medication has a 60-day expiration once opened. RCM1 confirmed that all nurses should be looking at expiration dates when administering medications. A facility policy titled, “Medication Storage -Storage of Medication” dated 01/25 noted “PROCEDURES…14. Outdated, contaminated, discontinued, or deteriorated medications…are immediately removed from stock…” 2) On 07/24/25 at 07:42 AM, observed Registered Nurse (RN)9 as she was administering medications. After RN9 prepared the medications and placed the blister packs back in the medication cart, RN9 walked to the resident's room. Observed the medication cart was not locked and unattended. After giving the medications to the resident, RN9 went back to the medication cart and noticed the cart not locked, RN9 then proceeded to lock the cart. On 07/24/25 at 08:30 AM, an interview was conducted with Resident Care Manager (RCM)2 at the nurse's station. Shared observation of the unlocked and unattended medication cart with RCM2. RCM2 confirmed that medication carts should always be locked and secured when not in use. On 07/25/25, review of the facility policy titled, Medication Storage – Storage of Medication dated 01/25 stated, . Medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized access.

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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. Based on observation and interview, the facility failed to ensure that one refrigerator was kept in a clean and sanitary condition in accordance with professional standards for food safety and resident food items were expired and not discarded. Both storing food items in an unsanitary refrigerator and not discarding expired food items has the potential to result in development of foodborne pathogens which may cause discomfort to the residents upon consumption and development of foodborne illnesses for the residents. Findings include:On 07/22/25 at 12:39 PM, an inspection of a refrigerator located in a room near the Team 1 and Team 2 nurses' station used to store resident food and liquids was done. The following was noted: [NAME] sediments in the compartments on the inside of the refrigerator door. Scattered red stains under the left side of a storage compartment in the refrigerator. Scattered red stains along the inside top edge of the freezer door. Scattered red stains and yellow sediments in a storage compartment of the freezer. Build up of yellow and brown debris at the bottom of the freezer.On 07/23/25 at 03:30 PM, an inspection of the same refrigerator was done with Resident Care Manager (RCM) 1 who confirmed seeing the same sediments, stains, and build up as listed above (07/22/25 at 12:39 PM). Two, unopened yogurt containers with a best by date of 06/25/25 noted on the containers were found in the freezer. RCM1 stated that the refrigerator was not clean, and the two yogurt containers were expired and proceeded to remove them from the freezer.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to ensure appropriate protective and preventative measures were performed to prevent infections and communicable diseases as evidenced by two staff members not removing gloves and not performing hand hygiene after completing incontinence care and before touching clean items for Resident (R) 1. This deficient practice has the potential to affect other residents who require assistance with care of bowel and bladder incontinence.Findings include:On 07/24/25 at 01:58 PM, observed Resident Care Manager (RCM) 1 and Licensed Practical Nurse (LPN) 10 providing incontinence care, specifically, cleaning of bowel movement incontinence for R1. Once incontinence care for R1was completed, observed RCM1 and LPN10 not removing gloves, not performing hand hygiene, and not donning a new pair of gloves before application of a clean adult incontinence brief, straightening out R1's linens, repositioning his body position, applying bilateral heel protectors, and placing the top sheet over his body.On 07/24/25 at 02:21 PM, interviewed RCM1 who stated that the gloves used while providing incontinence care for R1 should have been removed along with performing hand hygiene before touching R1's clean items and areas. A facility policy titled, Incontinence Care dated 06/19/23, stated, PROCEDURE .5. Wash all soiled skin areas.8. Remove gloves. Perform hand hygiene. 9. Replace incontinence pad or apply disposable brief as necessary.11. Replace top linen and position guest/resident.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pu'Uwai 'o Makaha	84-390 Jade Street Waianae, HI 96792

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 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. Based on observations, interviews and record review, the facility failed to provide the residents a safe and clean environment. The sink in one of the shower rooms had water leaking into a plastic bucket and spilling onto the floor. This deficient practice could affect all residents and staff in the facility if the environment is not kept in good repair, putting them at risk for falls and injury.Findings include: On 07/23/25 at 08:32 AM, while standing in the hallway outside of the resident's shower room, observed a bucket almost full of water that was dripping from the faucet and underneath the sink. Water was dripping on the bathroom floor from the pipes under the sink. No cautionary signs such as Wet Floor signs were observed to warn staff and residents. On 07/23/25 at 08:32 AM, an interview was done with Resident Care Manager (RCM2) and she confirmed the floor was wet from the leaking sink and stated that she will notify the maintenance department. On 07/23/25 at 09:17 AM, concurrent observation and interview done with Director of Maintenance (DOM) and Maintenance Staff (MS). Observed both staff fixing the leaking sink. When asked what day they were notified of the water leak, both staff confirmed they were notified one week ago. When asked about cautionary signs, DOM confirmed wet floor signage should have been used to warn residents and staff of the unsafe condition in the shower room. On 07/23/25, reviewed facility policy titled Routine Cleaning and Disinfection directs the facility, . to provide a safe, sanitary environment. 6. Cautionary signs such as wet floor signs will be utilized and posted .