STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125048	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ann Pearl Nursing Facility	45-181 Waikalua Road Kaneohe, HI 96744

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 observation, interview, and record review, the facility failed to provide adequate supervision and interventions resulting in 2 elopement incidents (01/19/26 and 01/28/26) for Resident (R) 36. This deficient practice created the likelihood for a serious adverse outcome (e.g. serious bodily injury and /or death from being hit by a car) due to open access to a busy road from the facility entrance and adjacent parking lot. Findings include:The Office of Health Care Assurance (OHCA) received a facility-reported incident (FRI) Intake #2721134, documenting an incident of elopement that occurred on 01/19/26 at 06:28 PM by R36. A second FRI, Intake # 2731191, was received by OHCA on 01/28/26 at 05:54 PM, regarding another elopement by R36 that occurred on 01/28/26 at 04:10 PM, 9 days after the first incident (01/19/26). The State Agency (SA) entered the facility on 03/11/26 for annual recertification survey where both FRIs were investigated.R36 is a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including DMII (diabetes), adjustment disorder with mixed anxiety and depressed mood, hypertension, chronic kidney disease, hypothyroidism, obstructive sleep apnea. R36 was discharged from the facility on 02/28/26.On 03/10/26 at 2:00 PM a review of R36's progress notes in the electronic health record (EHR) were reviewed. There were 5 entries documented ranging from 10/27/25 to 12/16/25 that R36 verbalized wanting to go home and/or verbalizing wanting to go home with frequent phone calls made to family. There was 1 episode documented on 11/6/25 where R36 was asking other staff and residents to take her home. There were 6 entries documented ranging from 10/22/25 to 12/05/25 that R36 was wandering in the facility and stating wanting to go home. There were 27 entries documented ranging from 10/28/25 to 01/18/26 that R36 was ambulating near facility entrance/exit door or displaying exit seeking behavior. On 01/19/26 at 06:10 pm R36 eloped through the main exit doors. There was no plan preventing elopement for R36 prior to the 01/19/26 elopement incident as evidenced by: 1) R36's care plan did not address the wandering and exit seeking behaviors that occurred prior to the 01/19/26 elopement incident; 2) Activity Aide took R36 for a stroll outside the facility on 01/19/26 at approximately 4:00 PM and left resident alone sitting at a table outside. A documented note by Resident Care Manager (RCM) 1, dated 01/202/26 stated, I was walking out of the office door near the Pikake lanai with [DON] when we noticed that resident [R36] was sitting at the resident smoking tent alone. I asked [DON] is she allowed to be there and she said no and that she was going to get her back inside. On 03/11/26 at 06:45 AM, upon entry through the main entrance, SA observed the doors were unlocked and lacked an alarm or automatic locking mechanism. There was no indication that the door could secure automatically to prevent an elopement. The main entrance opened up to a large open area with no reception or receiving area observed.On 03/11/26 at 07:00 AM, the facility investigation packets received for the 01/19/26 and 01/28/26 elopement incidents were reviewed. On 01/19/26 and 01/28/26, R36 was found in the parking lot near the first handicap stall. For both incidents, staff were not aware of R36's elopement until notified/made aware by another facility resident.On 03/11/26 at 10:11 AM, the Administrator and Director of Nursing (DON) were interviewed:-The Administrator stated there was currently no electronic wander management system in place. There was a doorbell (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at the front entrance doors and when it rings, staff supposed to look up but confirmed that the R36 did walk out on her own through the front door on 01/19/26 and 01/28/26. -The DON confirmed resident was having exit seeking behaviors prior to the 01/19/26 elopement incident and that on 01/19/26 she was functionally at the supervision level and could ambulate with a front wheeled walker.-The facility Elopement Risk Evaluation was completed on 10/16/25 and DON stated score was a 0. On 10/28/25 another evaluation was completed with a score of 2. The bottom of the evaluation stated, A score of 1 or greater = At risk for elopement. The Administrator was asked how the evaluation is utilized and she stated that we review change in score and determine what other interventions need to be done. No interventions regarding resident risk of elopement were identified prior to the 01/19/26 incident.-A concurrent review of a root cause analysis (RCA) done by the DON after the 01/19/26 incident listed more frequent rounding as an intervention. The Administrator stated, increased monitoring is everyone's responsibility and not one on one. SA requested documentation for increased monitoring. On 03/12/26 at 05:45 PM, reviewed facility Behavior Monitoring and Interventions Reports received for 01/01/26 to 02/28/26 which included a section that could be marked for Elopement/Exit Seeking. Upon review, times were documented once for each shift (day, evening, night) and did not reflect increased times being documented after the 01/19/26 and 01/28/26 elopement incidences. Most of the documentation was marked as, No Behaviors Observed which was inconsistent with the exit seeking episodes noted in R36's progress notes. No other documentation reflecting increased monitoring was presented by the facility.-The Administrator and DON were asked during the interview about education provided after the 01/19/26 and 01/28/26 incidents. The Administrator stated that an elopement drill was conducted and an in-service that included the topic of elopement was provided. A review of the facility education documents provided by the facility showed an Elopement Drill dated 02/12/26. An in-service titled, Survey 2026 Prep & Updates that included 2 questions, 6. Who runs a Code Pink? 7. Is Elopement Risk only Nursing's responsibility . was conducted on 02/18/26 and 02/19/26. The dates for the elopement drill and in-services did not reflect that elopement education was provided after the first elopement incident (01/19/26) and that timely education was provided after both elopement incidents to assist in keeping R36 safe. The signature records also did not reflect that majority of staff participated.-During the interview, the Administrator also stated that online education regarding elopement was assigned to staff in January 2026. SA received the online education on Managing Elopement from the facility labeled, Learner Status at the top of the first page, a date of 03/09/26 following, and Due Date Range of 03/01/26 - 03/09/26. This did not reflect that it was done in January 2026 after the initial elopement (01/19/26).On 03/11/26 at 11:53 AM, the Administrator stated there was still one resident, R6, listed as an elopement risk.