

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  125050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/27/2024
NAME OF PROVIDER OR SUPPLIER  Hale Malamalama		STREET ADDRESS, CITY, STATE, ZIP CODE  6163 Summer Street Honolulu, HI 96821	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48351</p> <p>Based on observations, interviews, and record review, the facility failed to treat one of 13 sampled residents (Resident (R) 4) with respect and dignity while assisting with R4's meal. This deficient practice has the potential to negatively affect R4's environment in promoting and maintaining her quality of life. This deficient practice has the potential to affect the residents that need assistance with their meals.</p> <p>Findings Include:</p> <p>Observation was conducted on 09/24/24 at 11:42 AM in R4's room. Certified Nurse Aid (CNA) 7 was observed assisting R4 with her lunch. CNA7 was sitting on R4's bed while assisting her with feeding. CNA7 stated that sometimes the CNAs would sit on R4's bed when assisting her with her meals due to a shortage of stools. At the same time and in the same room, CNA15 was observed assisting an unsampled resident with feeding. CNA15 was standing up. CNA15 stated that she usually stands up when assisting residents with their meals because it is easier.</p> <p>Interview was conducted with the Director of Nursing (DON) on 09/26/24 at 09:26 AM at the nurse's station. DON confirmed that CNAs who are assisting a resident with feeding should sitting down at eye level with the resident. DON stated that standing up and sitting down on a resident's bed while assisting with feeding is not okay.</p> <p>A review of the facility policy titled, Resident Rights-Respect, Dignity/Right to Have Personal Property, dated 04/24, was conducted. The policy documented, The resident has a right to be treated with respect and dignity .</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>38870</p> <p>Based on observation, interview, and record review. The facility failed to provide an orderly and comfortable home for the residents residing in the facility, due to the following:</p> <p>Resident care equipment that was not maintained was stored in one resident's room which gave it a disorderly and cluttered appearance. Staff working at night were noisy and disrupted the residents sleep. The temperature in the dining room/ activity room was too cold at night.</p> <p>The efforts of the resident council to address the concerns failed to resolve the problems that were ongoing. The deficient practice affects the rights of the residents to live in a homelike and comfortable environment.</p> <p>Findings include:</p> <p>1)During an observation in Resident (R) 186 room on 09/25/24 at 08:13, an Oxygen (O2) concentrator was observed under the counter next to the right side of the bed and two (O2) tanks next to the bed. Verified with staff that R186 is not currently being treated with O2. One wheelchair, two footrests, and a cane were found on the floor at the head of the bed (behind the bed against the wall).</p> <p>During a second observation on 09/26/24 at 07:32 AM in R186 room, the regulator on top of one of the O2 tanks showed the needle was in the red zone indicating it was empty and needed to be refilled. The O2 concentrator under the counter on the right side of the bed had a smeared service date. An unlabeled O2 tubing with a nasal canula was laying on the counter.</p> <p>Requested and reviewed the policy Facility Preventive Maintenance (05/08).</p> <p>Purpose:</p> <p>In order to provide a safe environment for residents and staff, it is important that all care devices and equipment used in .be checked and maintained on a regular basis.</p> <p>Procedures. The following items will be inspected, checked, tested and/ or cleaned: Nursing Equipment: Oxygen Concentrators Check weekly. Service when necessary.</p> <p>Oxygen tanks. Check weekly and ensure that they are operational and full.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Director of Nursing (DON) on 09/27/24 at 09:30 AM in the central area next to the nurse's station. The surveyor asked the DON, if it is the facilities responsibility to provide the maintenance checks on the O2 equipment? The DON explained that R186 is on Hospice and the Hospice Nurse will report any problems with the equipment to the DON and the facility will either contact the provider to replace it or contact the maintenance supervisor to repair it. Routine maintenance is done by the facility maintenance staff. The surveyor shared observations of the equipment (O2 Concentrator with no maintenance date and the O2 tank that is empty in the room). The DON confirmed that the maintenance staff should be checking it. The facility Maintenance Supervisor was unavailable for interview.</p> <p>2) Surveyor received and reviewed the following concerns from the long-term care ombudsman who recently visited the facility: Housekeeping staff were spraying disinfectant and cleaning the dining room while the residents were eating; housekeeping staff mopped the floors without placing a caution wet floor sign; ongoing concerns about the dining room being too cold for the residents.</p> <p>Resident Council minutes dated 06/17/24 reviewed. Old business concerns and resolutions: R150 had a concern about the dining room temperature, but matter was resolved.</p> <p>Agenda new business .R150 stated that the temperature in the dining room has been set to cold again and even when the residents complain that they are cold, nothing is being done .He also suggests that staff should consider the feelings of the residents and be considerate because the nursing facility is considered their home and they should be able to feel comfortable. He also stated that staff are still noisy at night which keeps him up and asked if the staff can be disciplined so that the behavior is not repeated The Social Worker (SW) stated this ongoing problem has been reported to the DON and the Administrator and awaiting their response .</p> <p>Resident Council minutes dated 08/19/24 reviewed. Old business/ concerns .R150 had a concern about the dining room temperature and claimed that the Air Conditioner (A/C) is always cold again. SW notified the resident that a sign was placed on the (A/C) to show what temperature to leave it on but resident said no staff follows that or even takes the time to read it .New business R150 states that the staff continues to be noisy at night which prevents him from sleeping.</p> <p>Interview with the SW on 09/27/24 at 08:55 AM in the central area next to the nurses station. The surveyor asked the SW how the residents' concerns were addressed and if they were resolved? The complaints that I haven't been able to resolve has been about the staff being too loud at night, and the residents are complaining that they can't get any sleep. We have talked to the staff and the ombudsman who has made suggestions. We have asked the staff to close the windows while they are on their break. The break room is right outside of the dining room. We have talked to the two charge nurses to remind the staff to be quiet. The other complaint that hasn't been resolved has been about the A/C being too cold. We have talked to the staff and put up a sign on the A/C but there is one staff who doesn't adhere to it.</p> <p>Interview with the DON on 09/27/24 at 09:30 AM. The surveyor asked the DON how the residents' complaints about noise at night is being addressed. The DON stated, once a week there is a huddle with the nursing staff. They are reminded to keep it quiet at night. The issue with the air conditioner is not a problem on the dayshift, but there is a staff person in the evening that is not following the rules about the A/C. We keep reminding the staff person, who is not following what the sign says is on the eve shift to turn the A/C off in the evening.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>48351</p> <p>Based on record review and interview, the facility failed to revise one of the 13 sampled residents (Resident (R) 18) care plan after R18 had a fall with injury. This deficient practice has the potential to place R18 at risk for future falls and has the potential to affect all 34 residents in the facility.</p> <p>Findings Include:</p> <p>A review of R18's Electronic Health Record (EHR) was conducted. R18's EHR documented that R18 had a fall on 07/19/24. A Registered Nurse (RN) note documented, Resident was conscious and responsive. Skin tears on right arm measuring 3x2cm, left arm 4x1 cm, right leg 2x1cm and abrasion on left elbow 1.5x0.2 cm. Bump and redness on the side of his right face. R18 was then sent out to the emergency room via ambulance.</p> <p>A review of R18's care plan was conducted. R18's care plan did not contain any update or revision for R18's plan of care after the fall on 07/19/24.</p> <p>Interview was conducted with the Director of Nursing (DON) on 09/26/24 at 09:26 AM at the nurse's station. After reviewing R18's care plan, DON confirmed that R18's care plan should have been revised after his fall on 07/19/24.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>48351</p> <p>Based on observations, interview, and facility policy review, the facility failed to ensure drugs and biologicals are stored in a locked compartment. Proper storage of medications is necessary to promote safe administration practices and to decrease the risk for diversion of resident's medications. This deficient practice has the potential to affect all 34 of the residents in the facility.</p> <p>Findings Include:</p> <p>Concurrent observation and interview were conducted on 09/26/24 at 07:10 AM in the dining room. The medication cart was seen left unattended and unlocked. Two staff members were seen walking pass the medication cart while accompanying a resident. Registered Nurse (RN) 4 was observed administering medications to R27, who was seated at the dining table. RN5 was facing the resident. When RN5 was queried about the unlocked medication cart, RN4 stated that she was nearby, but confirmed that the medication cart should have been locked since it was left unattended.</p> <p>Interview was conducted with the Director of Nursing (DON) on 09/26/24 at 09:30 AM at the nurse's station. DON confirmed that nurses should lock the medication cart when left unattended.</p> <p>A review of the facility policy titled, Medication Storage in the Facility, was conducted. The policy documented, Medications and biologicals are stored safely, securely, and properly .medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>48351</p> <p>Based on interviews and record review, the facility failed to create an annual Performance Improvement Project (PIP) that focuses on high risk or problem prone areas identified through the data collection and analysis. This deficient practice has the potential to negatively affect all the residents' overall wellbeing.</p> <p>Findings Include:</p> <p>Interview and facility document review were concurrently conducted on 09/27/24 at 10:33 AM with the facility Administrator. The facility's Quality Assurance and Performance Improvement (QAPI) binders did not contain documents on an annual Performance Improvement Project (PIP). Administrator confirmed that the committee met quarterly to discuss current facility issues and improvements but did not have an official PIP.</p> <p>A review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Plan for HALE MALAMALAMA, was conducted. The policy documented, In addition, the QAPI Committee will implement any PIP topics indicated by data analysis .PIPs are implemented in accordance with CMS' protocol for conducting PIPs .</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>38870</p> <p>Based on observation, interview and review of policy, the facility failed to ensure housekeeping services were being provided to the residents in a manner that was safe. Housekeeping staff were cleaning the dining tables with chemicals that were toxic to the skin and eyes while residents were seated at the table. The deficient practices places the residents at risk for illness.</p> <p>Findings include:</p> <p>Observations made in the dining room on 09/25/24 at 11:52 AM. Two House Keeping (HK) workers observed to spray the residents dining tables with a chemical cleaner then wipe with a cloth, while the Residents were sitting at the table. Observed residents at two tables with glasses of liquid and straws. The surveyor pointed to a caution label on the spray bottle that said Danger, keep out of reach of children and asked the HK Supervisor (HKS) if it's a safe chemical to be spraying on the table when the residents are sitting there. HKS said its safe, we spray it like this, and demonstrated holding the cloth over the table and squirt the spray under the cloth. The chemical was labeled quat sanitizing spray.</p> <p>The surveyor requested the Material Safety Data Sheet (MSDS) information on the sanitizing quat, with uses and restrictions during use and the housekeeping policy from the Infection Preventionist (IP) at 12:15 PM.</p> <p>Received and reviewed the Cleaning and Disinfection/ Non-Critical Care and Share Equipment 04/24. Environmental services staff should use their discretion when cleaning to prevent potential chemical harm to the residents.</p> <p>Received and reviewed the MSDS for OASIS 146 Multi-quat Sanitizer.</p> <p>.First Aid Measures.</p> <p>in case of eye contact Rinse with plenty of water.</p> <p>In case of skin contact Rinse with plenty of water.</p> <p>If swallowed Rinse mouth. Get medical attention if symptoms occur.</p> <p>if inhaled Get medical attention if symptoms occur.</p> <p>Section 11. Toxicological information.</p> <p>Causes eye and skin irritation.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview with the HKS on 09/27/24 at 07:40 AM. The surveyor asked the HKS to explain the use of the 146 quat. If it is diluted and what surface areas are they using it for. Stated that it is used in the dining room on the tables and chairs. Surveyor asked if it is safe, and how does he ensure the staff are using it properly, without exposing the residents to chemicals? The HKS said it can burn the skin, so we spray a small amount under the cloth then wipe the area. The surveyor asked HKS how is he monitoring his staff and ensuring they are safely applying the chemical? The surveyor explained that HK4 was observed to be openly spraying the table then wiping it with the towel where the residents were sitting with their drink glasses. HKS said, I tell them they need to do it this way, spray under the towel then wipe. The HKS said the long-term care ombudsman was here at the facility and told us not to be spraying the chemical while the residents are eating.</p>