

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Hale Makua Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 1540 Lower Main Street Wailuku, HI 96793	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39754</p> <p>Based on an interview with one Resident (R)42 of seven residents sampled, the facility failed to provide reasonable accommodations related to R42's showering and meals. As a result of this deficiency, there was risk for decline of R42's maintenance of independent functioning, dignity and well-being.</p> <p>Findings include:</p> <p>During resident interview on 05/02/24 at 09:30AM, R42 stated when facility staffing was short, it would take around thirty minutes to an hour for staff to respond to his call light. R42 said he needed assistance reaching for the soap when taking a shower. Also, it would take longer (around forty-five minutes) for staff to deliver meals to resident's rooms when short staffed.</p> <p>Review of Electronic Health Record showed that R42 was admitted on [DATE] with diagnoses including Respiratory Failure, Chronic Obstructive Pulmonary Disease, Pulmonary Edema, Congestive Heart Failure, Atrial Fibrillation, Pulmonary Arterial Hypertension, Atherosclerotic Heart Disease, Cardiomegaly, Abdominal Aortic Aneurysm, High Cholesterol.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245</p> <p>Based on interview and record review, the facility failed to appropriately perform diabetes management for 1 of 18 residents (Resident 22) in the sample by failing to ensure his blood sugars were measured, and his sliding scale insulin was administered at the appropriate times. As a result of this deficient practice, Resident (R)22 was placed at risk for an avoidable decline and/or injury related to his diabetes. This deficient practice has the potential to affect all the residents at the facility with insulin-dependent diabetes.</p> <p>Findings include:</p> <p>1) Resident (R)22 is a [AGE] year-old male admitted on [DATE] with diagnoses that include spondylosis, lumbosacral region (age-related change of the bones (vertebrae) and discs of the lower spine, causing pain), fusion of spine, thoracic region (a surgical procedure in which two or more bones (vertebrae) of the upper and middle part of the back are joined together), osteoarthritis, right shoulder (the wearing down of the protective tissue at the ends of bones), chronic pain, and diabetes with long-term use of insulin.</p> <p>On 05/01/24 at 08:51 AM, an interview was done with R22 at his bedside. When asked about his blood sugar checks and his sliding scale insulin, R22 reported that sometimes the nurses check his blood sugar and give him his sliding scale insulin after he has already begun eating his meal, or even after he has completed it. When R22 has commented on it, the nurses have told him, We have a one-hour grace period.</p> <p>A review of R22's provider orders noted an order for Insulin Lispro sliding scale (dosage is titrated based on blood sugar result) before meals, scheduled for 06:00 AM, 11:00 AM, and 04:00 PM, and started on 03/15/24. From 02/22/24 to 03/15/24, there was an order for Insulin Aspart sliding scale before meals, also scheduled for 06:00 AM, 11:00 AM, and 04:00 PM.</p> <p>A review of R22's Medication Administration Record (MAR) for March 2024 noted that the sliding scale insulin was documented as Late Administration: Charted Late [reflecting it was given more than one hour after it was due] 20 times. A review of R22's MAR for April 2024 noted late administration of his sliding scale insulin documented 11 times.</p> <p>On 05/03/24 at 09:36 AM, an interview was done with the Director of Nursing (DON) and the Administrative Nurse/Charge Nurse (CN)3 in the DON office. Both the DON and CN3 confirmed that sliding scale insulin should be administered immediately after the blood sugar is taken, and documented on the MAR immediately after it is given. They also agreed that since the insulin dose is dependent on the blood sugar result, which would be altered with food consumption, it is crucial that it is done before the resident begins eating to decrease the risk of a hypoglycemic (low blood sugar) episode. As a result, the DON and CN3 confirmed that there is no grace period for sliding scale insulin and late administration(s) should not be happening. Upon concurrent review of the late administrations documented on the MARs with CN3, she expressed surprise that there were so many and explained that the Unit Managers should be monitoring that daily.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Treatment of Type 2 Diabetes Mellitus in the Older Patient, last updated on 01/04/24, and found at https://sso.uptodate.com/contents/treatment-of-type-2-diabetes-mellitus-in-the-older-patient?search=slding%20scal%20insulin%20in%20an%20older%20adult&sectionRank=1&usage_type=default&anchor=H33&source=machineLearning&selectedTitle=1%7E150&display_rank=1#H4 noted the following: Hypoglycemia should be avoided in older adults . Even a mild episode of hypoglycemia may lead to acute, adverse outcomes in frail older patients, including falls and fractures.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783</p> <p>Based on observation, interview, and record review, the facility failed to ensure 2 of 7 residents (Residents 62 and 29) sampled were free from accident hazards. The facility failed to develop effective interventions to prevent avoidable falls for Resident (R)62, and R29 was transferred from his bed to a shower chair using a mechanical lift device he had not been evaluated as safe to use. Placing residents at risk of avoidable accidents and injuries by not providing the appropriate assessments, planning, monitoring, and recommendations, and/or implementing the appropriate interventions is a deficient practice that has the potential to affect all the residents at the facility.</p> <p>Findings include:</p> <p>1) R62 is a [AGE] year-old resident admitted to the facility on [DATE]. Diagnoses include but are not limited to traumatic brain injury following a motor vehicular accident; fractures to base of skull, maxilla (upper jawbone), orbit (eye socket), nasal bones, right clavicle (collar bone), and left carpal bone (wrist); and acute respiratory failure.</p> <p>On 04/30/24 at 12:50 PM, observed R62 lying supine in bed with his eyes closed. Height of bed was at the lowest setting and there was a fall mat on the right side of the bed.</p> <p>Review of R62's Electronic Health Record (EHR) conducted. Fall risk assessment was completed on 02/29/24 and R62 had a score of 10 indicating he is at a moderate fall risk. After his first fall on 03/08/24, another fall risk assessment was done and score increased to 17 indicating a high fall risk. The most recent fall risk assessment was done on 04/26/24 with a score of 25 indicating a high fall risk. Care plan interventions included offering snacks and activities, use of pommel cushion while on wheelchair to prevent sliding, frequent reminders to not attempt to stand up from wheelchair alone, use of a tab alarm, provide assistance with toileting, provide physical therapy as ordered, use padded fall mats around bed, increased staff supervision, setting bed at lowest position with wheels locked, and medication review to assess for medications that increase the risk of falls. Care plan also documented that the resident prefers not to use side rails while in bed and refused to use a helmet as recommended by the physician. Progress notes revealed that R62 had falls on the following dates:</p> <p>03/08/24 at 10:30 AM, found on the floor in his room.</p> <p>03/14/24 at 08:00 AM, found kneeling on the floor in his room after hearing tab alarm.</p> <p>03/20/24 at 04:05 PM, staff witnessed R62 fall to the floor in front of the nurses' station while trying to stand up from wheelchair.</p> <p>03/21/24 at 08:50 AM, found sitting on the floor in his room while responding to tab alarm.</p> <p>03/23/24 at 09:55 AM, staff witnessed R62 fall to the floor in front of the Activities Department walkway while trying to stand up from wheelchair.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>03/29/24 at 07:55 AM, staff witnessed R62 fall to the floor in front of the nurses' station while trying to stand up from wheelchair.</p> <p>03/30/24 at 05:25 AM, found sitting on the floor in his room while responding to tab alarm.</p> <p>04/02/24 at 07:15 AM, staff witnessed R62 trying to get up from the wheelchair and fell hitting his face on the frame of the door. Wheelchair was parked in front of the nurses' station.</p> <p>04/20/24 at 11:00 AM, staff witnessed R62 fall to the floor in the common area near the nurses' station trying to stand up from wheelchair.</p> <p>04/24/24 at 03:50 PM, staff witnessed R62 fall on the floor at the TV area in front of the nurses' station while trying to stand up from the wheelchair by pulling himself up using the railings.</p> <p>04/26/24 at 11:15 AM, found sitting on the floor next to his wheelchair at the table area near the nurses' station.</p> <p>On 05/03/24 at 09:27 AM, an interview was conducted with Charge Nurse (CN) 1 at the nurses' station. Asked CN1 how often do the staff check on R62. CN1 said staff check on R62 every hour and document it on the log that is kept in the nurses' station. Reviewed log with CN1, hourly checks were initiated on 03/08/24 after the first fall. When asked if the hourly checks were effective given that R62 has had 10 more falls since it was implemented, CN1 said I think it is working, the falls happen on various times. CN1 also stated that the facility provides a sitter when R62 becomes restless, was prescribed an antianxiety medication on 03/28/24 to help him calm down and started on physical therapy on 03/13/24 to strengthen his legs.</p> <p>On 05/03/24 at 10:05 AM, an interview was conducted with the Director of Nursing (DON) by the Lanai wing nurses' station. Asked DON if the hourly checks are enough to prevent more falls for R62. DON said the facility is not able to provide one-on-one supervision for any residents 24 hours a day. DON also stated that they hired extra clerical staff that help monitor R62 in the afternoon and therapy was started to strengthen his legs to prevent him from falling when he attempts to stand up from the wheelchair. DON added that the facility does not want to implement the use of restraints on R62.</p> <p>43245</p> <p>2) Resident (R)29 is an [AGE] year-old male admitted to the facility on [DATE] for long-term care following a stroke. A review of R29's Minimum Data Set (MDS) quarterly assessment with an assessment reference date (ARD) of 04/03/24, Section GG-Functional Abilities and Goals, noted that R29 is completely dependent on staff for all Activities of Daily Living (ADLs) such as eating, toileting, dressing, and bathing, as well as all mobility activities such as rolling from side to side in bed, sitting up in bed, and transferring in and out of bed. Of note is that on the last three MDS assessments documented, no weight-bearing activities were evaluated, and instead were documented as Not attempted due to medical condition or safety concerns.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/02/24 at 02:29 PM, observed Certified Nurse Aide (CNA)24 and CNA3 preparing to use a mechanical lift to transfer R29 from his bed to a shower chair. The mechanical lift used for the transfer was one that lifts the resident from the seated position at the edge of the bed to a standing position on the lift itself. Observed that R29 was unable to sit up or remain in the seated position at the edge of the bed on his own. CNA24 and CNA3 had difficulty manually lifting R29 to the seated position and holding him there as the lift harness was applied. R29 fell back onto the bed in a semi-reclined position at one point and had to be manually lifted to a seated position a second time. Observed CNA24 lift both R29's feet up and place them on the lift platform without his assistance. Then observed CNA24 lift R29's right hand and place it on the right handle of the lift. CNA24 was able to grip the handle once his hand was placed there. CNA3 then lifted R29's left hand to do the same on the left handle, however she had to open R29's left hand, place it on the handle, and manually close his fingers around the handle. R29 was unable to tighten his grip onto the left handle as he had done on the right. At no point during the transfer were the wheels on the mechanical lift placed in a locked position. When asked if the lift wheels should be locked for safety, CNA3 responded that they should have locked the wheels before lifting R29 from the seated position to standing.</p> <p>A review of the User Instruction Manual for the mechanical lift used revealed the following:</p> <p>The . [mechanical lift] is suitable for patients in the SITTING position only who have a degree of weight-bearing ability but require assistance to stand.</p> <p>A review of R29's comprehensive care plan for ADLs revealed no determination of weight-bearing ability, but does note the following:</p> <p>I [R29] am dependent on staff for all my ADLs.</p> <p>I [R29] am non-ambulatory.</p> <p>A review of the last Physical Therapy PT Evaluation & Plan of Treatment, dated 09/06/22, revealed that R29 had been referred for transfer and strength training. The therapist documented that he was unable to complete an assessment of R29's level of function due to his refusal to participate. Further review of the document notes that no plan of treatment had been developed, and no recommendations were made.</p> <p>On 05/03/24 at 08:55 AM, an interview was done with the Director of Rehab [rehabilitation] (DOR) in the Therapy Gym. DOR confirmed that she could not find a Physical Therapy Evaluation since 2022. Upon concurrent review of the 2022 Physical Therapy Evaluation, DOR agreed that she would expect to see recommendations made, especially if unable to complete an assessment, probably the highest safety recommendations. DOR stated that although she is not a Physical Therapist (PT) so she cannot speak for the PT that performed the 2022 evaluation, when she does an evaluation of her own as an Occupational Therapist (OT) or as the DOR, she would first ask the nursing staff what they are doing, then she would watch a transfer, and make recommendations based on that. If she were unable to do that (speak to nursing staff and watch a transfer), she would most likely recommend using the maximum level of safety for all transfers, meaning a mechanical lift used for fully dependent residents who are unable to participate or help in the transfer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Since the PT who conducted the 2022 evaluation was unavailable for interview, on 05/03/24 at 09:05 AM, a phone interview was done with PT5, who stated he was not familiar with R29. When asked what he would look for when assessing a resident for functional ability/mobility specifically to make a recommendation regarding the mechanical lift used with R29, PT5 responded that he would want to ensure the resident was able to place their feet on the floor/lift device, able to extend their knees, able to hold themselves up in a seated position, and able to tighten their grasp on the lift handles on both sides.</p> <p>On 05/03/24 at 09:08 AM, further questioning was done of DOR, who stated she was familiar with R29's occupational therapy function. DOR confirmed that R29 would not be able to tighten his grasp on the lift handle on the left side due to contractures in his left hand.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>39754</p> <p>Based on observations, staff interview and review of policy, the facility failed to label the humidified sterile water bottle for one Resident (R)177 of five residents sampled. As a result of this deficiency, the facility put R177 at increase risk for sterile water contamination.</p> <p>Findings include:</p> <p>During observation of R177's oxygen delivery set up on 05/01/24 at 08:30 AM, the humidified Sterile Water Bottle was not labeled with the date and time opened.</p> <p>Staff interview on 05/01/24 at 08:40 AM, Charge Nurse (CN)2 acknowledged that the Sterile Water Bottle should have been labeled with the date and time opened and initials. CN2 subsequently replaced the oxygen delivery/sterile water bottle with new equipment.</p> <p>Review of facility policy on Oxygen Administration read Purpose; To deliver oxygen to the guest/resident when insufficient oxygen is being carried by the blood to the tissues. Procedure . c. Attach humidifier to flowmeter by screwing nut onto the flow meter if needed. If the humidifier has an audible alarm, check this by adjusting the flow rate and pinching the tubing until the alarm sounds . g. Label humidifier with date and time opened and your initials .</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245</p> <p>Based on observation, interview, and record review, the facility failed to manage pain adequately for 1 of 4 residents (Resident 22) sampled for pain. Specifically, the facility failed to ensure that Resident (R)22's pain regimen was implemented on a timely basis. As a result of this deficient practice, R22 was prevented from attaining or maintaining his highest practicable level of well-being.</p> <p>Findings include:</p> <p>Resident (R)22 is a [AGE] year-old male admitted on [DATE] with diagnoses that include but are not limited to, spondylosis, lumbosacral region (age-related change of the bones (vertebrae) and discs of the lower spine, causing pain), fusion of spine, thoracic region (a surgical procedure in which two or more bones (vertebrae) of the upper and middle part of the back are joined together), osteoarthritis, right shoulder (the wearing down of the protective tissue at the ends of bones), and chronic pain.</p> <p>On 05/01/24 at 08:55 AM, an interview was done with R22 at his bedside. R22 was sitting up in bed with a stiff posture, leaning awkwardly to the right, and appeared as if he did not want to move his head. When asked about pain, R22 stated I'm always in pain, it's so hard to get my pain managed. When they [nursing staff] constantly late [with his routine/scheduled pain medication] that's when I get upset. R22 complained that between 03:00 PM and 11:00 PM especially, his routine/scheduled pain medications are always late. When he complains to the nurses about his medication being late, he is told we have a 1-hour grace period. R22 rated his current pain level as a 7 out of 10, located to his neck and lower back. R22 repeated, I cannot handle when the meds [medications] come late.</p> <p>A review of R22's provider orders noted the following orders for routine/scheduled pain medications:</p> <p>Acetaminophen 1000 milligrams (mg) three times a day, scheduled for 08:00 AM, 02:00 PM, and 08:00 PM.</p> <p>Baclofen 10mg three times a day, scheduled for 08:00 AM, 02:00 PM, and 08:00 PM.</p> <p>Gabapentin 400mg (increased to 600mg on 04/25/24) three times a day, scheduled for 08:00 AM, 02:00 PM, and 08:00 PM.</p> <p>Marinol 10mg twice a day, scheduled for 08:00 AM and 04:00 PM.</p> <p>Oxycodone 20mg routine every six hours, scheduled for 08:00 AM, 02:00 PM, 08:00 PM, and 02:00 AM.</p> <p>A review of R22's Medication Administration Record (MAR) for March 2024 revealed the following:</p> <p>Acetaminophen documented as Late Administration: Charted Late [reflecting it was given more than one hour after it was due] 6 times.</p> <p>Baclofen and Gabapentin documented as given late 7 times.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Marinol documented as given late 9 times.</p> <p>Oxycodone documented as given late 10 times.</p> <p>A review of R22's MAR for April 2024 revealed the following:</p> <p>Acetaminophen, Baclofen, and Gabapentin documented as given late 13 times.</p> <p>Marinol documented as given late 6 times.</p> <p>Oxycodone documented as given late 20 times. 4 of those times, the reason was documented as R22 was sleeping at the scheduled time, and the medication was documented as given between 1 hour, 21 minutes to 3 hours, 16 minutes late.</p> <p>On 05/01/24 at 10:17 AM, a follow-up interview was done with R22 at his bedside. When told that it was noted that his scheduled pain medications were sometimes documented as given late due to the resident sleeping, R22 became visibly upset and stated that he has told staff numerous times that he wants to be woken up to take his routine pain medication around-the-clock so that he can keep his pain at a tolerable level. That shouldn't matter if I am sleeping, they should still wake me up and give it to me!</p> <p>On 05/03/24 at 09:36 AM, an interview was done with the Director of Nursing (DON) and the Administrative Nurse/Charge Nurse (CN)3 in the DON office. Both the DON and CN3 agreed that every effort should be made to give scheduled pain medication on time and confirmed that all nurses should be documenting the administration of any medication on the MAR immediately after giving it. If the medication is a controlled substance (e.g., Marinol and Oxycodone), all nurses should be signing it out on the narcotic log, giving it immediately, then documenting it on the MAR as administered immediately after that. Surveyor confirmed with both that if a medication is documented as Late Administration, it means it was given an hour or more after it was scheduled.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245</p> <p>Based on observation, interview, and record review, the facility failed to ensure pharmacy services included an effective process to provide routine drugs to meet the needs of the residents, and failed to dispose of medications past their expiration date. As a result of this deficient practice, 2 residents (Residents 33 and 14) had routine medications that were out of stock, and residents who needed intravenous fluid were placed at risk of receiving expired fluids. This deficient practice has the potential to affect any patient taking medication.</p> <p>Findings include:</p> <p>1) On [DATE] at 08:43 AM, while observing medication pass with Registered Nurse (RN)8, it was noted that the Losartan (a medication for high blood pressure) 100 milligrams due at 09:00 AM for Resident (R)14 was out of stock. RN8 stated he would check the emergency kit (E-kit) for it.</p> <p>On [DATE] at 09:08 AM, RN8 confirmed that there was no Losartan in the E-kit. RN8 called the pharmacy to check on when it would be delivered and stated he would also call the doctor to inform him the medication was out of stock. RN8 explained that he ordered the medication refill on [DATE], but he also gave the last dose in the blister pack then. RN8 confirmed that it should have been ordered before it got down to the last dose.</p> <p>On [DATE] at 09:37 AM, an interview was done with Unit Manager/Charge Nurse (CN)1 at the nurses' station. CN1 stated that the expectation is when starting the last row of medications in the blister pack (meaning 7 days left of medications), nurses should start re-ordering the medication either through the electronic health record (EHR)/pharmacy interface or by faxing the refill sticker from the blister pack to the pharmacy. CN1 confirmed that since there is only one refill sticker per blister pack, the refill sticker method can only be done once.</p> <p>On [DATE] at 10:14 AM, CN1 provided documentation that the refill sticker for the Losartan was faxed to the pharmacy on [DATE]. CN1 confirmed that it appeared that the re-ordering process was not followed which led to the medication now being out of stock.</p> <p>Review of R14's EHR revealed that on [DATE] at 09:46 AM, RN8 documented the Losartan due at 09:00 AM as Not Administered: Drug/Item Unavailable. At 09:50 AM, RN8 entered a one-time order from the provider to administer the Losartan at 01:00 PM. A second order was entered changing the scheduled time due to 02:00 PM, and the medication was administered successfully between 02:00 PM and 03:00 PM.</p> <p>47783</p> <p>2) On [DATE] at 11:48 AM, observed R33 lying in bed with head elevated. When asked how she was doing, R33 complained of back pain. Asked R33 if she takes medication for the pain. R33 said she did not get any pain medications yet and asked for the nurse. Notified Charge Nurse (CN) 1 of R33's complaint of back pain. CN1 said R33 has a routine pain medication scheduled and will administer it.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Hale Makua Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 1540 Lower Main Street Wailuku, HI 96793	
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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R33's Electronic Health Record (EHR) conducted. R33 is a [AGE] year-old resident admitted to the facility on [DATE]. Orders for pain medication were Gabapentin 300 mg (milligrams) at bedtime for low back pain, Morphine 2 mg every 4 hours PRN (as needed) for pain 8-.d+[DATE], and Tramadol 50 mg twice a day and every 4 hours PRN for pain. Documented under Progress Notes on [DATE] at 01:48 PM, Called pharmacy re: (regarding) gabapentin refill. Per pharmacy tech, this is being process [sic] for evening delivery. Another note was entered on [DATE] at 09:46 AM stated. Gabapentin was not delivered. LN (licensed nurse) again called pharmacy .</p> <p>On [DATE] at 09:48 AM, concurrent interview and record review conducted with CN1 at the nurses' station. Asked CN1 if the Gabapentin for R33 was delivered in time for her evening dose. CN1 checked the Medication Administration Record (MAR) to see if it was administered. A note on the MAR entered for [DATE] at 06:00 PM stated, Not Administered: Drug/Item Unavailable. Asked CN1 how early does the staff reorder routine medications. CN1 said they reorder seven days prior to the last available dose. Asked CN1 why R33's Gabapentin was not available if it was reordered 7 days prior to the last dose. CN1 said she will check the delivery records to see if it was delivered. After looking at the list of medications delivered on [DATE], CN1 said that Gabapentin for R33 was not included on the list for that day. CN1 also showed another document titled pending Orders Report from the contracted pharmacy stating Gabapentin was last filled on [DATE] with a handwritten note stating, need signed receipt by nurse that it was received on [DATE]. CN1 said that the nurse that received the medications delivered checked what was physically delivered against what is listed on the delivery record to make sure it matches. Delivered medications are not checked against a list of what was ordered so they are not able to tell if an ordered medication was missing. CN1 added that the Gabapentin for R33 was delivered on [DATE] so the resident only missed one dose and the attending physician was notified.</p> <p>3) On [DATE] at 08:57 AM, inspection of the medication storage room was conducted with CN1. Five one-liter bags of 0.9% Sodium Chloride solution were found in one of the storage cabinets with an expiration date of [DATE]. One of the five bags did not have a protective plastic cover. CN1 confirmed that the five bags were past their expiration date and should have been discarded.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>43245</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, as evidenced by 2 medication errors observed out of 28 opportunities for errors, for an error rate of 7%. Safe and timely medication administration practices are essential for the health and well-being of the residents. As a result of this deficient practice, two residents were placed at risk of negative outcomes due to medication errors. This deficient practice has the potential to affect all residents in the facility taking medications administered by staff.</p> <p>Findings include:</p> <p>1) On 05/02/24 at 08:43 AM, observed medication pass with Registered Nurse (RN)8 as he prepared and gave medications to Resident (R)14. Observed RN8 prepare R14's Polyethylene Glycol (a laxative) 17 grams (gm) using 8 ounces of water, split into two 4-ounce cups. One cup of prepared liquid was administered with R14's other oral medications. The second cup of prepared liquid (with half of the Polyethylene Glycol dose) was left at the bedside with R14 while RN8 left the room to prepare and administer medications to R31.</p> <p>On 05/02/24 at 09:51 AM, an interview was done with Unit Manager/Charge Nurse (CN)1 at the nurses' station. CN1 confirmed that medications should not be left at the bedside. When CN1 was asked specifically about Polyethylene Glycol, she responded, that is a medication so it should not be left at the bedside.</p> <p>Review of Section 7.5, Medication Administration Orals policy, dated 01/23, noted the following:</p> <p>Administer medication and remain with resident while medication is swallowed.</p> <p>Review of R14's provider orders revealed no orders for self-administration of any medications.</p> <p>2) On 05/02/24 at 08:55 AM, observed RN8 prepare and administer medications to R31, among them was his Metformin 1000 milligrams, due at 09:00 AM. When RN8 entered R31's room with his medications, it was observed that there was no breakfast tray at his bedside.</p> <p>At 09:10 AM, confirmed with R31 that he had long since completed breakfast.</p> <p>During a review of R31's provider orders, the following was noted regarding his Metformin 1000mg:</p> <p>Special Instructions: give with meal.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47783</p> <p>Based on observations, interviews and record review, the facility failed to ensure food and drink items were stored in accordance with professional standards for food service safety. This deficient practice has the potential to affect all residents who have their meals served by the facility placing them at risk for food-borne illnesses.</p> <p>Findings include:</p> <p>On 04/30/24 at 10:03 AM, initial tour of the off-site kitchen conducted with the Nutrition Service Director (NSD). During the inspection of the walk-in refrigerator, an opened one-gallon jug of milk was found without an open and discard date. NSD confirmed that the opened jug of milk was not labeled properly. Another refrigerator was inspected just outside the walk-in refrigerator. Two opened bottles of juice and two opened jars of mayonnaise were found with no open and discard dates. NSD confirmed that the items were not labeled properly and said that the staff are usually good at making sure all food items are labeled as soon as they are opened. Inspected freezer near the food preparation area, found a partially covered box of cheesecake with no open and discard date. NSD confirmed that all opened food and drink items should be labeled with the open and discard dates, and all items stored in the refrigerator and freezer should be covered.</p> <p>On 05/02/24 at 09:59 AM, inspected nourishment refrigerator in the front wing of the facility with Certified Nurse Aide (CNA) 19. Found an open container of sports drink and a bowl of food covered with foil. Both items were labeled with the residents' names but there were no open and discard dates noted. Asked CNA19 how long are the food items good for if kept in the refrigerator. CNA19 said three days. When asked how he would know if three days have passed since there was no open date noted on the food items, CNA19 said he will ask the residents since both were verbally responsive.</p> <p>Review of the facility policy titled, Labeling and Dating Policy conducted. The policy stated, . If food is held for more than 24 hours, it shall be clearly marked to indicate the date or day by which the food item shall be consumed on the premises, sold or discarded. The policy included a table with a list of food and drink items and stated, Items with use by date, defer to that date UNLESS opened, then use the policy below. Under the 3 Days column, it included Hot or cold food leftover. Under the 7 Days column, it included Milk, Juices/Iced Tea. Under the 30 Days column, it included Mayonnaise.</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39754</p> <p>Based on resident interviews, staff interviews, record reviews and review of policy, the facility failed to ensure that two Residents (R)23, R25 of seven residents sampled understood the Binding Arbitration Agreement. As a result of this deficiency, R23, R25 did not fully understand the details of the Agreement.</p> <p>Findings include:</p> <p>R23 interviewed on 05/01/24 at 02:45 PM, stated that she did not remember signing the Binding Arbitration Agreement. Also, did not know what the Agreement was about.</p> <p>Review of Electronic Health Record (EHR) showed that R23 was admitted to the facility 05/22/23 and signed the Binding Arbitration Agreement 05/28/23.</p> <p>R25 interviewed on 05/01/24 at 03:10 PM, stated that she signed all admission papers but did not remember the discussion of the Binding Arbitration Agreement. Also, R25 was not familiar with any details of the Agreement when presented to her.</p> <p>Review of EHR showed that R25 was admitted to the facility on [DATE] and signed her own Binding Arbitration Agreement 05/28/23.</p> <p>Staff interview on 05/03/24 at 10:30 AM, Administrative (Admin) Assistant said the facility follows the Binding Arbitration Agreement policy during the admission process for all residents.</p> <p>Review of facility policy on Binding Arbitration Agreements read; Policy, This facility asks all residents to enter into an agreement for binding arbitration. We do not require binding arbitration as a condition of admission to, or as a requirement to continue to receive care at this facility . Policy explanation and compliance guidelines; When explaining the arbitration agreement, the facility shall: a. Explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at this facility. b. Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. c. Ensure the resident or his or her representative acknowledges that he or she understands the agreement .</p>		