

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 01/30/2026
NAME OF PROVIDER OR SUPPLIER Hale Makua - Wailuku		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)		
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the State Long Term Care Ombudsmen (LTCO) was provided written notification of resident's transfer/discharge from the facility for two of three residents sampled for hospitalizations. Findings include: On 01/28/26 at 3:40 PM, requested a copy of the written notification of transfer/discharge to the LTCO, for Resident (R) 76's transfer to the hospital on [DATE]. On 01/29/26 at 11:32 AM, reviewed a notification of transfer/discharge. The notification provided, documented it was faxed to the LTCO on 01/28/26 at 4:32 PM, after the documentation was requested by the surveyor. On 01/30/26 at 8:27 AM, conducted an interview with the Social Worker (SW) regarding R76's notice of transfer to the LTCO. The SW confirmed the notification to the LTCO was not sent and that the notification is normally faxed within a day or two of the resident's transfer, but in this case, the family did not sign the document, and it was not sent to the LTCO. 2) On 01/28/2026 at 08:45 AM, interview with R6 noted that he went to the hospital on [DATE] for left leg above the knee amputation. On 01/29/2026 at 1:00 PM, record review of R6's Electronic Health Record (EHR) noted the notice of resident discharge/transfer and bed hold policy was sent to R6's representative, however, no notification to the LTCO was done for the transfer. Requested confirmation of notification, but what was provided by the Administrator was a fax confirmation sent to the LTCO dated 01/29/26 at 3:50 PM, which was after the documentation was requested. On 01/29/2026 at 3:50 pm, interview with the SW confirmed that she only faxed the notification to the LTCO today and was missed being sent out with November's batch of notifications.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, staff interviews, and record review, the facility failed to implement the fall risk plan of care for fall mats to be placed at the sides of the bed for one out of 19 residents sampled for comprehensive care plan review. The deficient practice increased the resident's risk for falls. Findings Include: On 01/27/2026 at 1:00 PM, observed Resident (R) 47 sitting in a wheelchair outside his room. R47 had on a right arm sling. When asked what happened to his right arm, R47 stated he fell yesterday around 3:00 PM when he tried to pick up something he had dropped on the floor. R47 said that he had to be taken to the emergency room (ER) for evaluation and is awaiting the results of his x-ray. R47 stated he is weak on his right side due to a previous stroke and has blurred vision. On 1/28/26 at 08:32 AM, observed R47 asleep in bed and no floor mats in place. At 11:00 AM, observed R47 outside in wheelchair. No floor mats in place in room or at bedside. On 1/29/26 at 08:30 AM, observed R47 asleep in bed and no fall mats in place. On 01/29/26 at 10:05 AM, interview with the Unit Manager (UM) and confirmed that resident fell outside while sitting on his wheelchair in the hallway when he tried to reach for something he dropped. Reviewed Fall Risk care plan dated 09/03/25 with the UM and confirmed that floor mats should be in place at all times. The UM noted that the care plan should be revised to remove the floor mats as R47 has not fallen while he has been in bed. The UM confirmed that R47's Falls care plan was revised on 01/29/26 after the fall but it still included continue interventions on the at-risk plan, which notes, to have fall mats on both sides of the bed, and fall mats in place at all times. The UM further acknowledged that floor mats were not in place for a while and not in place after R47's fall and as noted in the revised care plan. On 01/30/26 at 08:40 AM, observed resident in bed and still no fall mats in place. On 01/30/26 at 11:00 AM, review of the facility's Fall Prevention and Management Program Guidelines, it notes in the E. Dynamic Treatment Plan section, 2. As information is updated, it needs to be communicated to the staff. a. Staff 3. Individual care plan developed, communicated with staff and implemented. Review of the facility's Comprehensive Care Plans policy, in the Policy Statement it notes, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident/guest that includes measurable objectives and timeframes to meet a resident/guest's medical, nursing needs that are identified in the resident's/guest's comprehensive assessment.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interviews, and record reviews, the facility failed to remove R6's pressure dressing after four hours from the completion of his hemodialysis (HD) treatment for one of two residents sampled for dialysis services. The deficient practice was not consistent with professional standards of practice and put the resident at risk for complications to his access site. Findings Include: On 01/28/2026 08:45 AM, observed Resident (R) 6's left upper arm (LUA) fistula pressure dressing still on from the previous day which was more than 15 hours after he completed the dialysis treatment. R6 said that he came back from dialysis yesterday around 5:00 PM and that staff sometimes do not check his fistula access every shift and will leave the dressing on because of bleeding. At 09:00 AM, conducted an interview with Registered Nurse (RN) 1. When asked what the facility's policy was on removing a pressure dressing after a resident return from their hemodialysis treatment, RN1 stated she was not sure but would find out. At 10:30 AM, RN1 informed the surveyor that they can remove dressing after 24 hours after dialysis and that it is in the care plan. On 01/29/2026 at 09:00 AM, record review of R6's electronic health record (EHR) noted that there were no physician's orders to leave the dressing on for 24 hours. Review of the care plan noted an entry to remove dressing within 24 hours of return, was created on 01/28/26 by the Unit Manager (UM). On 01/29/2026 at 10:00 AM, interview with the UM confirmed that there were no physician's orders to leave the dressing on for 24 hours and acknowledged that he included it in the care plan yesterday. The UM noted that he included it since he could not find any intervention to address R6's access bleeding. Reviewed the progress notes with the UM and confirmed that there was no documentation of R6's access site bleeding and he was not made aware of any issues. The UM acknowledged that any problems with access site, bleeding, or any interventions outside of the standard of practice to address the access site problems requires physician notification. On 01/30/26 at 09:00 AM, review of the facility's Hemodialysis policy, dated 10/01/24, in the Care of the Vascular Access section, it notes, 7. Assess patient after hemodialysis treatment by checking for at least the following: b. Pressure dressing post dialysis will not be removed from the AVF/AVG site for a minimum of 4 hours. C. Monitor of access site-after dialysis check for bleeding.i. if bleeding occurs, apply direct pressure until it is controlled. Notify provider if bleeding lasts longer than 30 minutes or is severe.		