

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  125059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/22/2024
NAME OF PROVIDER OR SUPPLIER  Palolo Chinese Home		STREET ADDRESS, CITY, STATE, ZIP CODE  2459 10th Avenue Honolulu, HI 96816	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>48351</p> <p>Based on interviews, and record review, the facility failed to implement interventions in a care plan for one out of three sampled residents (Resident (R) 2). This deficient practice resulted in R2 sustaining a fall and has the potential to affect all the residents in the facility.</p> <p>Findings Include:</p> <p>(Cross reference to F689-Free Of Accident Hazards/Supervision/Devices)</p> <p>A review of R2's Electronic Health Record (EHR) was conducted on 11/22/24. R2's EHR noted that R2 sustained an unwitnessed fall in the dining room on 10/24/24 at 08:40 PM. Furthermore, R2's current care plan noted the following interventions to prevent her from falling, 6/17/24 Staff to ensure common areas (i.e. dining room) are supervised at all times. Staff to communicate with one another when they have to leave the premises.</p> <p>A review of the facility's investigative note on R2's fall on 10/24/24 was conducted. The investigative note documented, ROOT CAUSE: .Resident was with family most of the evening and reportedly fell about 5 minutes after family left. Poor communication resulted in staff not supervising the dining room in this 5 minutes window when family left and staff away attending to other residents .</p> <p>Interview was conducted with the Nurse Manager (NM), with the Administrator present, on 11/22/24 at 10:28 AM. NM stated that after R2's family left, there was a 5-minute window when R2 was left unsupervised in the dining room prior to her fall. NM confirmed that during that time, the interventions in R2's care plan was not being implemented. NM also stated that residents scored as a high risk for falls in the falls risk evaluation would require close supervision.</p> <p>Interview was conducted with Certified Nurse Assistant (CNA) 3 on 11/22/24 at 10:48 AM via phone call. CNA3 confirmed that R2 was by herself when she found her on the ground in the dining room on 10/24/24.</p> <p>A review of the facility's policy titled, Baseline, Comprehensive, and Discharge Care Plan, with a last revised date of 04/17/23, was conducted. The policy noted, 12. The facility staff or those acting on behalf of the facility will implement the interventions to assist the resident to achieve care plan goals and objectives.</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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48351</p> <p>Based on interviews and record review, the facility failed to provide adequate supervision to prevent two out of three sampled residents (Resident (R) 1 and R2) from falling. Due to this deficient practice R1 sustained a fall that resulted in a laceration to the head. This deficient practice has the potential to affect all the residents who are at risks for falls in the facility.</p> <p>Findings Include:</p> <p>(Cross reference to F656-Develop/Implement Comprehensive Care Plan)</p> <p>1)R1 is a [AGE] year-old male admitted to the facility on [DATE]. R1 has a diagnosis that include, but not limited to, spinal stenosis, mild cognitive impairment, and generalized arthritis. A review of R1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/06/24, noted that R1's score for Brief Interview for Mental Status (BIMS) was a seven. Which means, R1 has severe cognitive impairment.</p> <p>A review of the Facility Reported Incident (FRI) document, dated 09/01/24, was conducted. On the FRI, the facility reported that a Certified Nurse Assistant (CNA) 1 had assisted R1 into the outdoor courtyard in his wheelchair. CNA1 then left R1 unsupervised for a few minutes to return to the dining room. Once she returned, CNA1 found R1, on the ground. R1's body was draped over the concrete retainer curb, with face down on rocks.</p> <p>A review of R1's Electronic Health Record (EHR) was conducted on 11/21/24. R1's EHR contained an assessment for his falls risk, dated 07/05/2024. The falls risk noted a score of 13, which the falls risk tool described, If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls.</p> <p>Interview was conducted on 11/21/24 at 09:08 AM with the Nurse Manager (NM). NM stated that R1 was left unsupervised outdoors for about 5 minutes. NM confirmed that R1 should not have been left unsupervised.</p> <p>Interview was conducted with CNA2 on 11/21/24 at 12:45 PM. CNA2 stated that R1 loves to go outside, and when he is outside, he is usually supervised by either a rehab nurse aide or a staff from the activities department.</p> <p>Interview was conducted with Registered Nurse (RN)1 on 11/21/24 at 01:15 PM. RN1 stated that she was working at the time of the incident and called 911 after R1 sustained the fall. When RN1 was asked if residents were ever left unsupervised, RN1 answered, Residents are supposed to be supervised when they are outside.</p> <p>Interview was conducted with the NM, with the Administrator present, on 11/22/24 at 10:28 AM. NM stated that residents scored as a high risk for falls in the falls risk evaluation would require close supervision.</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>2)R2 is an [AGE] year-old female admitted to the facility on [DATE]. R2 has medical diagnosis that includes, but not limited to, Alzheimer's disease, parkinsonism, dementia, and anxiety disorder. A review of R2's MDS with an ARD of 10/22/24, noted that R2's score for BIMS was a 0. Which means, R2 had severe cognitive impairment.</p> <p>A review of R2's EHR was conducted on 11/22/24. R2's EHR contained an assessment for her falls risk, dated 10/17/2024. The falls risk noted a score of 15, which the falls risk tool described, If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls.</p> <p>R2's EHR noted that R2 had sustained an unwitnessed fall in the dining room on 10/24/24 at 08:40 PM. R2 was observed being restless prior to the fall. A review of R2's care plan noted the following intervention to prevent R2 from falling, 6/17/24 Staff to ensure common areas (i.e. dining room) are supervised at all times. Staff to communicate with one another when they have to leave the premises.</p> <p>Interview was conducted with the Nurse Manager (NM), with the Administrator present, on 11/22/24 at 10:28 AM. NM stated that residents scored as a high risk for falls in the falls risk evaluation would require close supervision.</p>