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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125062	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hale Kupuna Heritage Home, LLC	4297a Omao Road Koloa, HI 96756

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 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 record review and interviews, the facility failed to implement the person-centered intervention to provide stand by assist in the care plan to prevent falls for one resident (R) 54 sampled for Free of accident hazards/Supervision/Devices Develop/Implement Comprehensive Care Plan. The deficient practice resulted in an unsupervised fall that resulted in a major injury which caused pain and suffering for the resident. Findings include:Cross reference to F689.Electronic Health Record (EHR) reviewed. R54 had an unwitnessed fall in building 1 on the B unit on 02/06/26, that resulted in a hip fracture, transfer to the emergency room (ER) for evaluation and surgery to repair the right hip fracture. Cross reference to F689.Care plan reviewed: Revision on 01/23/2026. Focus: The resident is at risk for falls related to debility, legally blind, congestive heart failure, Diabetes Mellitus, medication side effects and fall history. Prior to the fall on 02/06/26, R54 had two falls in the facility on 12/29/25; witnessed fall-fell onto buttocks while fixing clothing by mirror; and on 01/19/2026, guided fall off balance while walking. Goal: Resident will be free of falls through the review date. Target date 03/25/26.Intervention: Standby assist with ambulation. Updated 01/22/2026. Interview with RN 25 on 03/12/26 at 11:05 AM. RN25 verified that R54 had a fall that was unwitnessed and said R54 needs assistance because she would suddenly stand up without warning and she was unsteady and she needed someone there when she was walking. Interview with RN50 on 03/12/26 at 11:19 AM. Asked RN50 what level of supervision did R54 need since she was a fall risk. RN50 said that R54 needed eyes on her in case she tried to get up. It just so happened that I had to walk away at that time, it was unfortunate and the CNA was busy with another resident so there was no one there to assist her to get up. Final Investigation Summary and Determination received reviewed on 03/12/26.The fall occurred while the resident attempted unsupervised ambulation without her walker.the care plan had not been updated to fully reflect the resident's current needs related to consistent walker use. Additionally, staff did not fully adhere to the existing care plan interventions regarding availability and use of the walker at the time of the incident.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hale Kupuna Heritage Home, LLC	4297a Omao Road Koloa, HI 96756

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(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 - Actual harm 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, interviews and record reviews. The facility failed to provide supervision based on the individual resident's assessed needs and the risks identified in the environment to prevent accidents for three of three Residents (R) 7, R5 and R54. The deficient practices resulted in falls with major injuries for two (R5 and R54) of three residents sampled for free of accident hazards/supervision/devices, and an injury for one resident, R7. Findings Include: Cross reference to F725 sufficient nursing staff. Observation and interview with R7 sitting in a chair at the dining room table on [DATE] at 11:14 AM in the dining area on C wing. Observed an adhesive bandage on top of his head. Asked R7 what happened to his head. R7 said he fell in the bathroom last Saturday and went to the emergency room (ER). R7 added that they did all the tests and he passed but he is still having some pain. Asked if he is taking any pain medicine for his head and R7 replied that he is currently having some pain and the nurse is preparing his medications. Asked if he had any falls before that and he said yes, he had a couple of falls. Observed with a walker next to him. He said he can only walk with a walker. Observation on [DATE] at 12:50 PM in the C wing dining table, observed R7 without the bandage on top of his head. Observed a large circular purple area of his skin that looked like a bruise. Also observed an excoriation to his right upper cheek.R7's Electronic Health Record (EHR) reviewed on [DATE]. Care plan reviewed. Focus: The resident has had an actual fall: [DATE] unwitnessed fall-head pain, right lateral pain, right ear bruise. [DATE] unwitnessed fall - bruising to back and toe abrasion. [DATE] unwitnessed fall slid out of bed (OOB) reaching for urinal no injury. [DATE]: unwitnessed fall in bathroom abrasion and hematoma to top of head.Health Status Note [DATE] 12:08 At 1045, R7 had an unwitnessed fall in the bathroom. R7 stated he was attempting to adjust his bottoms and walking with front wheel walker (FWW). Resident was found on the right side of his body, stating that he hit his head. Noted two abrasions to top of head. Left lateral abrasion measures 1.5 centimeters (cm x 0.5 cm with small amount of serosanguineous (bloody) drainage and medial abrasion measured 1 cm x 0.1 cm without any drainage. First abrasion with surrounding bruise and lump, measuring 2 cm x 1.5 cm. Lump noted to right lateral side of head, measuring 3 cm x 5 cm. This writer & two other nursing staff assisted resident up from the floor. Resident complained of (c/o) pain at 8/10 (on 0-10 pain scale) aching pain to head & nausea. As needed (PRN) ondansetron (medication for nausea) given. Notified physician.Received order to send resident to ER status post (S/P) unwitnessed fall & altered mental status (AMS). Emergency services contracted at 1120 & arrived to facility at 1150. Left facility at 1155 with paramedics.Registered Nurse (RN) 33 interviewed on [DATE] at 10:23 AM. Asked RN33 if she was aware of R7's fall that occurred on [DATE]. RN33 said she was working in the morning. The fall happened at 10:45 AM in the bathroom. It was one of the housekeepers that let her know that R7 had fallen. He was found on his right side in the bathroom on the floor, his pants and underwear were on his thighs and his door was closed, he usually will pull the call light string, but he didn't do that. We saw him on the floor, did his neuro checks, his walker was lying on the ground, and his belongings were on the ground. Me and the Certified Nurse Aide (CNA) helped get him off the ground. He sustained injuries on top of his head. He complained of pain to his head and had nausea. He had rubber slippers on. We assisted him up. He wanted to lie down. I notified the staff managers and the doctor; he said to send him out. He had nausea, he sustained two bruises on top of his head and left lateral side, applied first aid, and a lump by his left lateral abrasion and another bump on his right lateral side. Prior to that he had a fall the month prior. Since this fall, he has been having more weaknesses. We encourage him to use his walker. If he gets weaker, he uses his wheelchair. It was the housekeeping staff that heard him saying help me, help me. He was on the ground. The call light is mounted on the wall by the toilet, and he was by the door. I do think he needs more supervision. He is good with his walker but since the fall I noticed he is on the weaker side. 2) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Hale Kupuna Heritage Home, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4297a Omao Road Koloa, HI 96756	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R5 was interviewed on [DATE] at 11:43 AM on the D wing in the activity area. Asked R5 if she had a fall in the facility. R5 stated that she fell in October of 2025. R5 explained that she tried to stand up in her new wheelchair and fell on her face. R5 said that her niece is a retired physical therapist, (PT) and she said it shouldn't have happened. It happened at night; the CNA was in the room helping the other resident.I had 8 staples in my head when I had the fall. Fall should not have happened. My sister was so angry. I think it was because of short staffing. EHR reviewed on [DATE]. R5 is a [AGE] year-old female with diagnosis that includes Dysphagia, History of falling, generalized muscle weakness. admitted to the facility on [DATE].Minimum Data Set (MDS) sig change assessment with an assessment reference date (ARD) of [DATE] reviewed. R5 was coded with 1 fall with major injury. The previous assessment with an ARD of [DATE] (before R5's fall) was reviewed and compared with the assessment on [DATE]. R5 showed a decline in eight of the ten areas measured in GG0170, Mobility. Progress notes reviewed on [DATE]. Resident fell from wheelchair on [DATE]. Was sent out to ER for evaluation and treatment. Health Status Note dated [DATE] 01:30. R5 was found on the floor by the CNA and Charge Nurse (CN 5) at 2355. She was face down in a push up position. She stated that she had stood up from her wheelchair and was not expecting it to be so high, because she had received a new wheelchair. She was helped up by two staff members to her wheelchair and neuro checks were initiated . Assessed for injuries and found approximately a two-inch laceration that was actively bleeding. R5 was assisted into her wheelchair by the Charge Nurse (CN) and CNA, and pressure was applied to her laceration with contusion forming on the left side of the face, left eye, and left cheek. Note text: ER notes dated [DATE] .Diagnosis. Closed fracture of left maxillary sinus. Closed fracture of left orbital floor, scalp laceration, and closed head injury.Note text: [DATE] 11:55. Back to facility around 0930 AM resident vomited x 3 on the way back. Left (Lt.) eye surrounding area with bruise 4.5 x 3 cm, and swelling noted. Lt. scalp area with laceration (7 cm long), with 8 staples with dry blood. Bruise to Lt. outer base of Lt. ear 3 x 5 cm.CNA45 was interviewed on [DATE] at 10:37 AM. Asked CNA45 how long she has worked at the facility and if she was working when R5 had a fall. CNA45 said that she has worked at the facility for 1 year as a CNA. I was working on the night shift. I was doing my rounds, and I was in the room with her neighbor and the curtain was closed. I heard the fall and opened the curtain and then I got the nurse. R5 was face down on the floor. 3) Facility reported incident reviewed. R54 was Found on [DATE] on the floor on the B wing of building 1 at 1:40 PM. No shoes or socks and no walker present. Found lying on her right side, she said she was trying to go to the bathroom. X-ray results indicating resident had a fracture to the right hip. She had surgery on [DATE] and was admitted to the intensive care unit (ICU) due to low blood pressure. Received and reviewed the hospital reports on [DATE]. Resident went to the ED, underwent surgery for repair of a hip fracture. admitted to the ICU post-surgery for hypotension. Resident died on [DATE].Death Summary from the acute care hospital dated [DATE] at 3:07 PM reviewed. Expiration Date: [DATE]. The patient was pronounced dead on: [DATE] at 2:45 PM. Principal cause of death; acute respiratory failure due to aspiration pneumonia. Reviewed R54's EHR on [DATE]. Orders reviewed: R54 was started on Quetiapine Fumarate (an antipsychotic medication) on [DATE]; and Mirtazapine (an anti-depressant medication) on [DATE]. Side effects of both medications include drowsiness, dizziness, and low blood pressure upon standing.Care plan reviewed: Cross reference to F656. Fall history: two falls in the facility on [DATE] and [DATE].Alert Note Focus: Date: [DATE] 22:21:11 Note Text: At 1340, R54 found on the floor. Stated was trying to go to the bathroom when she fell. Fall was unwitnessed. Complained of 10/10 right hip pain with movement. Unable to bend right leg. Taken to the ER at 2:30 PM. Resident diagnosed with right hip fracture and will be admitted .Final Investigation Summary and Determination received reviewed on [DATE].The fall occurred while the resident attempted unsupervised ambulation without her walker.the care plan had not been updated to fully reflect the resident's current needs related to consistent walker use. Additionally, staff did not fully adhere to the existing care plan interventions regarding availability and use of the walker at the time of the incident.Final Determination.The unwitnessed fall with right hip fracture is considered a (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	contributing event that exacerbated overall medical decline but was not the primary cause of death.Interview with RN 25 on [DATE] at 11:05 AM. RN25 said R54 was in the dining room during lunch, I believe R54 stood up and started walking. She was in the B wing dining room. I believe it was an unwitnessed fall. The kitchen staff was in the portable kitchen. One staff member was providing care in the bathroom, and the CN was called to assist another resident. Asked if R54 needed close supervision, RN25 said yes, line of sight, having the resident always in your vision because she would suddenly stand up without warning and she was unsteady and she needed someone there when she was walking. Asked her if there were enough staff to provide close enough supervision for the residents who need it. Usually there is another CNA but at that time she was helping with lunch. The dining staff were in the kitchen, and the Charge nurse had to leave briefly for something else. I think she needs standby assistance when she is walking with her walker because sometimes, she gets tired and might get weak. Interview with RN50 on [DATE] at 11:19 AM. Staff put R54 in the dining area in front of the nurse's station on the B wing watching the television (TV). I was sitting at the nurse's station documenting and got called away on the A side. RN50 said she was in another resident's room. When she was walking back to the nurses station and the kitchen staff notified her that R54 fell, and she was laying on her side I had asked the kitchen staff if she saw what happened, she said no, she saw her on the ground and she called for help and I checked her vitals, she had pain, her left leg or right leg. R54 couldn't bend her right leg without severe pain. I called the management and said I needed help, said R54 fell and she couldn't get up, they told me to call the ambulance. I got her paperwork and notified the on-call position. Shortly after Emergency medical services (EMS) came, they used a special transfer lift to get her up and she was in a lot of pain. She was alert and verbal and talking, she said she was cold and she said she was on the floor for 15 minutes before she could get up. I didn't even know the outcome and had to ask about her and found out she had expired.Asked RN50 what level of supervision did R54 needed since she was a fall risk. She needed eyes on her in case she tried to get up. It just so happened that I had to walk away at that time, it was unfortunate. It gets busy, and it gets stressful in that building. We always need more staff on that side because the staff are always on the A wing helping those Residents who need it. We keep asking for more help and continue to be short staffed. We need more staff for that B wing.Fall prevention and management program guidelines policy undated. Reviewed on [DATE].Fall Prevention and Management Guidelines Objectives: Reduce falls, minimize injuries, and ultimately improve the quality of life of resident through appropriate fall management.Minimize the severity of injuries sustained by the resident resulting from a fall.