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	09/06/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on interviews and record review, the facility failed to ensure the resident's right to be informed of the risk and benefits of proposed care for one Resident (R42) sampled. R42 had a decline in cognition due to the resident's health status. R42's cognition was not re-assessed for the resident's capacity to consent to medication(s)/treatment. The resident signed a consent for the use of antidepressant and antipsychotic medications. As a result of this deficient practice, residents with changes in condition which affect the resident's ability to understand the information required to make an informed decision are at risk for the potential of harm. Findings include: Review of the facility's policy and procedure, Psychotropic Medication (Original Effective Date 05/01/2021), use of documented, 5. Residents and/or representatives shall be educated on the risk and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions. R42 was admitted to the facility on [DATE] with diagnosis which include hemiplegia and hemiparesis of the left dominant side after an intracranial hemorrhage, epilepsy, hypertension, and cognitive communication deficits. Conducted a review of R42's Electronic Health Record (EHR). Review of the R42's physician orders documented orders for an antidepressant, Lexapro (escitalopram oxalate) tablet; 10 mg PO (by mouth) daily at 08:00 AM, ordered on 04/12/24, for depression, and an antipsychotic, Quetiapine (Seroquel) tablet; 25 mg PO at Bedtime 09:00 PM, ordered on 04/12/24, for restlessness and agitation. Review of the facility's Informed Consent for Psychotropic Medications for Lexapro and Seroquel documented R42 was unable to sign: verbal consent on 04/12/24 at 01:30 PM. The form was filled in by Registered Nurse (RN)109. Review of the resident's submitted Minimum Data Set (MDS) documented: - Admission MDS with an Assessment Reference Date (ARD) of 11/21/23 documented Section C. Cognitive Patterns, the Brief Interview for Mental Status (BIMS) score which is a test of the resident's cognition documented a score of 12, indicating the resident has moderate cognitive impairment. - Quarterly MDS with an ARD of 05/21/24, BIMS score was not completed (continued on next page)

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Quarterly MDS with an ARD of 08/08/24, BIMS score was 99, indicating the test could not be completed Review of R42's most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) on 08/08/24, Section B. B060. Speech Clarity, R42 has unclear speech- slurred or mumbled words; B.0700 Rarely/Never understtod or has the ability to express ideas and want both verbal and non-verbal expression. Review of a Nursing Home to Hospital Transfer Form on 08/3/24 at 06:52 AM documented, Patient cognitive status has changed with less ability to swallow secretions . Review of R42's progress notes documented the resident was sent out to the emergency room (ER) and/or admitted to the hospital a total of five (5) times since admitted to the facility: -02/06/24 at 11:12 PM, R42 was unresponsive. Emergency Medical Services (EMS) was activated, and the resident was sent to the emergency room (ER) via ambulance. (R42 was admitted to the Intensive Care Unit (ICU)) -02/07/24 at 03:16 AM, R42 will be admitted (to an acute hospital) for a Urinary Tract Infection (UTI) with sepsis (a life-threatening infection) and hypoxia (low levels of oxygen which could be life-threatening). -02/15/24 at 05:12 PM, R42 was admitted back to the facility. -03/02/24 at 10:35 AM, R42 went back to the ER and was admitted to the ICU at 10:58 PM due to unresponsiveness and rule out a cerebral vascular accident (CVA, stroke) -03/20/24 at 09:50 PM, R42 was admitted back to the facility -04/09/24 at 05:50 PM, R42 admitted to the hospital for seizures -04/12/24 at 03:34 PM, R42 returned to the facility -04/16/24 at 03:05 PM, R42 was drooling and unresponsive to sternal rub and verbal commands, sent to ER -04/16/24 at 08:21 PM, R42 returned to the facility -08/03/24 at 08:20 PM, R42 returned to the facility. -08/03/24 at 07:38 AM, R42 has a change in cognitive status with less ability to swallow secretions, sent to the ER (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/05/24 at 01:41 PM, conducted an interview with the Administrator regarding R42's cognitive ability to consent and requested a copy of a physician's assessment of the resident's ability to consent. Administrator stated R42 usually makes his own decisions. Asked if R42 has a designated representative in the event the resident is not able to make any decisions for himself. The Administrator did not know if the resident had a designated healthcare decision maker/representative and would get back to this surveyor with that information. On 09/05/24 at 02:44 PM, the Administrator confirmed, on admission, R42 could make his own decisions, but the resident has been sent out to the acute hospital several times since his original admission and the resident's cognition has declined since then. The Administrator also confirmed R42's capacity to consent has not been reassessed by the physician. On 09/06/24 at 11:25 AM, conducted a concurrent record review of R42's EHR and interview with the [NAME] President of Clinical Operations (VPCO), the Director of Nursing (DON) (new to the facility), the Infection Preventionist (IP) (assisted previous DON), Regional Nurse (RRN)1 and RRN2. Reviewed R42's progress notes (in the EHR) and R42's decline in health status, decline in cognition, and the facility's Informed Consent for Psychotropic Medications form which was verbally consented to by R42 on 04/12/24. VPCO, RRN1 and RRN2 confirmed R42's health and cognitive status has declined and the resident's capacity to consent should have reassessed but was not.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 42160 Based on interviews and record review, the facility failed to ensure one resident (Resident (R)39) was free from resident-to-resident abuse. R20 willful and intentionally punched R39 while smoking with staff present. As a result of this deficient practice, R39 sustained harm due to physical contact. The facility investigated, implemented updated interventions for resident safety, educated staff, and counseled the residents. Past non-compliance was determined as a result of the facility's corrective actions. Findings include: Review conducted for the Facility Reported Incident (FRI) document retrieved from Aspen Complaints/Incidents Tracking System (ACTS) #11078. Initial report was submitted to the Office of Healthcare Assurance on 07/10/24 and the completed report on 07/15/24. An altercation occurred when R39 requested to use R20's lighter and proceeded to take the lighter from R20's personal bag. R20 became upset that R39 was going into his personal bag and punched R39. Certified Nurse Aide (CNA)107 was present in the area, but not close enough to the residents to prevent R39 from being punched by R20. The residents were separated and R39 did not sustain a major injury. The facility corrective actions included but not limited to, immediately separated, and assessed the residents and conducted an investigation. Every 15-minute checks were implemented for both residents for 72-hours. Interventions implemented as a result of the altercation included both residents will not utilize the designated smoking area simultaneously throughout the day and each resident will have their own designated lighters which staff will provide to them during smoke breaks. CNA107 was permanently removed from the schedule due to failure to intervene in the resident-to-resident altercation. Facility staff were educated on the significance of separating residents during an altercation to prevent further escalation and to mitigate to potential of harm.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on interviews and record review, the facility failed to ensure an injury of unknown source was reported no later than 24 hours to the State Agency (SA) and Adult Protective Service (APS) for one resident (Resident (R)42) sampled. R42 sustained bruising to the left eyebrow and left eyelid. The source of the injury is unknown due to the resident's inability to verbalize what happened and it was not witnessed by staff. The facility confirmed the injury of unknow source was not reported to the SA or APS. Review of the SA's database, Aspen Complaints/Incident Tracking System (ACTS), confirmed the facility did not submit a report of R42's injury of unknown source. As a result of this deficient practice, residents are at risk for more than minimal harm. Findings include: (Cross Reference to F610 Investigate/prevent/correct Alleged Violations) Review of R42's Electronic Health Record (EHR) documented the resident was admitted to the facility on [DATE] with diagnosis which include hemiplegia and hemiparesis of the left dominant side after an intracranial hemorrhage, epilepsy, hypertension, and cognitive communication deficits. Review of R42's most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) on 08/08/24, Section B. B060. Speech Clarity, R42 has unclear speech- slurred or mumbled words; B.0700 Rarely/Never understood or has the ability to express ideas and want both verbal and non-verbal expression. A progress note written on 08/03/24 at 07:38 AM documented R42 was sent out to the emergency room (ER). A 08/03/24 at 08:24 PM confirmed upon returning from the ER, R42 had .no bruise . A nursing progress note written on 08/05/24 at 12:41 AM documented, Staff reported bruises to resident's left eyebrow and left eyelid measuring 2.5x2cm and 1x1.5cm respectively. Both are red. Unable to verbalize how he got the bruises. No verbal/non-verbal signs of pain/discomfort. MD response initiated. Review of an observation report (Skin Assessment) completed on 08/05/24 documented R42 sustained an eyebrow bruise 2.5 cm x 2 cm bruise and left eye 1 cm x 1.5 cm bruise to left eye. During a concurrent record review of R42's EHR and interview with the [NAME] President of Clinical Operations (VPCO), the Director of Nursing (DON) (new to the facility), the Infection Preventionist (IP) (assisted previous DON), Regional Nurse (RRN)1 and RRN2, on 09/06/24 at 11:25 AM, the IP confirmed the facility did not recognize R42's bruises on his left eyebrow and eyelid as an injury of unknown source and did not report it to the SA or to APS.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on interviews and record review, the facility failed to thoroughly investigate an injury of unknown origin to prevent further potential abuse for one resident (Resident (R)42). Staff reported bruises to R42's left eyebrow and eyelid and the source of the injury was unknown due to the resident's inability to verbalize what happened and the injury was not witnessed by staff. The facility did not identify the injury of unknown source as a potential for abuse of a vulnerable resident and did not investigate the potential source of the injury. As a result of this deficient practice, non-verbal and/or cognitive impaired residents are at risk for more than minimal harm. Findings include: (Cross Reference to F609 Reporting of Alleged Violations) Review of R42's Electronic Health Record (EHR) documented the resident was admitted to the facility on [DATE] with diagnosis which include hemiplegia and hemiparesis of the left dominant side after an intracranial hemorrhage, epilepsy, hypertension, and cognitive communication deficits. Review of R42's most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) on 08/08/24, Section B. B060. Speech Clarity, R42 has unclear speech- slurred or mumbled words; B.0700 Rarely/Never understood or can express ideas and want both verbal and non-verbal expression. A progress note written on 08/03/24 at 07:38 AM documented R42 was sent out to the emergency room (ER). A 08/03/24 at 08:24 PM confirmed upon returning from the ER, R42 had .no bruise . A nursing progress note written on 08/05/24 at 12:41 AM documented, Staff reported bruises to resident's left eyebrow and left eyelid measuring 2.5x2cm and 1x1.5cm respectively. Both are red. Unable to verbalize how he got the bruises. No verbal/non-verbal signs of pain/discomfort. MD response initiated. Review of an observation report (Skin Assessment) completed on 08/05/24 documented R42 sustained an eyebrow bruise 2.5 cm x 2 cm bruise and left eye 1 cm x 1.5 cm bruise to left eye. During an interview with the Administrator on 09/05/24 at 01:41 PM, requested the facility's investigation into the origin of the bruises staff reported on R42's left eyebrow and eyelid. During a follow-up interview with the Administrator at 02:44 PM, the Administrator confirmed the facility did not investigate how R42 sustained the bruises. During a concurrent record review of R42's EHR and interview with the [NAME] President of Clinical Operations (VPCO), the Director of Nursing (DON) (new to the facility), the Infection Preventionist (IP) (assisted previous DON), Regional Nurse (RRN)1 and RRN2, on 09/06/24 at 11:25 AM, the IP confirmed the facility did not recognize R42's bruises on his left eyebrow and eyelid as an injury of unknown source and did not conduct a thorough investigation.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 39754 Based on record review, staff interview and review of policy, the facility failed to provide written notice of bed-hold policy for one Resident (R)8 of two residents sampled. As a result of this deficiency, there was potential for miscommunication. Findings include: Review of the Electronic Health Record indicated that R8 was transferred to the hospital on 10/25/23 for low blood pressure, Urinary Tract Infection. Further review did not show any written notice of bed-hold policy to the resident and/or representative. During staff interview on 09/05/24 at 12:30 PM, Administrator acknowledged that the facility did not provide written notification of bed-hold policy to R8 and/or representative. Administrator also said that the facility had used other forms for discharge/written notification at that time when R8 was discharged . Review of facility policy on Discharge, Transfer of the Guest/Resident read; Purpose, to ensure safe departure from the facility, to provide sufficient information for continued care of the resident. Discharge, to leave the facility without plans or intention to return (e.g. discharge to home, a lower level of care or another care facility). Transfer, to leave the facility with plans or intention to return (e.g. transfer to an acute care facility for appropriate care). Procedure, explain discharge procedure and reason to resident and give copy of Transfer & Discharge notice / Bed hold policy as required. Include guest/resident representatives . Transfer . explain transfer and reason to the guest/resident and/or representative. Give copy of signed transfer or discharge notice to the resident and/or representative or person(s) responsible for care . Explain and give copy of Bed Hold form to the resident and/or representative . Documentation Guidelines, documentation may include . Complete Bed Hold notification form per facility policy .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on observations and staff interviews, the facility failed to: 1 and 2) ensure food were stored and frozen food thawed in a manner that avoids foodborne illness to the residents and 3) perform hand hygiene when distributing food trays to residents. As a result of these deficiencies, the facility put the residents at risk for foodborne illness. Findings include: 1) On 09/03/24 at 09:42 AM, initial observation of kitchen, thawing individually wrapped salmon fillets in water in a sink. Inquired with Kitchen Staff (KS)2 about the thawing salmon. KS2 stated they are having miso salmon for dinner and confirmed the salmon has been in the water for about one hour. Requested for KS2 to take the temperature of the salmon and the internal temperature of a larger fillet was 62.8 degrees Fahrenheit (F). 09/04/24 12:00 PM Conducted and interview with [NAME] (Food service Director and Dietician) shared observation with her of staff defrosting salmon and salmon was 62.8 degrees F. [NAME] confirmed temperature is out of range and salmon will defrost quicker than 40 lbs of chicken. Stated she would in-service staff on proper thawing of frozen foods. 2) On 09/03/24 at 09:38 AM, observed a scooper in the thickener container. Kitchen Manager (KM) confirmed the scooper should not be stored in the container. During an interview with the FSD ([NAME]) confirmed the scooper should not be stored in the same container as the product. 39754 3) On 09/03/24 at 12:15 PM, during observation of lunch on the Makalapua Unit, Manager 5 did not perform hand hygiene after removing gloves. Manager 5 proceeded to distribute lunch trays to three residents and did not perform any hand hygiene between or after the distribution of the trays. Staff interview on 09/04/24 at 12:00 PM, Administrator acknowledged that hand hygiene should have been done during distribution of lunch trays.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 38870 Based on observation, interview and policy review, the facility failed to ensure staff followed the Infection Prevention and Control policies and procedures for proper use of personal protective equipment (PPE) to follow proper infection control practices. Staff working with residents on isolation precautions did not correctly doff (remove) their PPE after providing care to Covid-19 positive residents in both resident care units in the facility. The same staff were also caring for residents who were not Covid-19 positive. The deficient practice places all residents in the facility at risk for healthcare associated infections that can result in significant adverse consequences. Findings include: Facility matrix and Electronic Health Record (EHR) reviewed. Resident (R)13 is a resident in room D3 documented with Covid-19 and on isolation precautions. A second Resident in room D2 was on transmission-based precautions due to an exposure to Covid-19. A third Resident, R33 in room B1 was documented Covid-19 positive and is also on isolation precautions. Observation on Makalapua unit on 09/03/24 at 10:43 AM. Observed Certified Nurse Aide (CNA)15 walk into room D2 wearing personal protective equipment (PPE), face shield, mask, gown, and gloves. A few minutes later CNA15 walked out of D2 still wearing the PPE and walked into room D3. A minute later CNA15 walked back out of room D3 and walked back into room D2 wearing the PPE. A few minutes later CNA15 walked out of D2 and doffed (removed) her PPE in the hall and walked into D3 and put it in the trash. Observation and interview with Registered Nurse (RN)25 on 09/03/24 at 11:00 AM. RN25 came out of D3 and approached the surveyor. The surveyor asked RN25 what is the process for donning (put on) and doffing PPE for the residents are on transmission-based precautions. RN25 said the staff don the PPE outside the room, then after they go into the room and provide care, they doff the PPE inside the room, and throw it in the trash bins in the room before going outside. When asked why the staff doffed the PPE outside of the room, RN25 said, we didn't have a bin in the room to throw away the PPE. During an observation and interview in R33's room on 09/05/24 at 11:15 AM with CNA20, this surveyor was preparing to exit the room and asked how to doff the PPE. CNA20 said take-off gloves, gown, and face shield but you don't need to remove the N95, you don't need to change that one. Surveyor asked CNA20, I don't need to change my mask? CNA20 stated, only the gown, gloves, and face shield. Interview with the Infection Preventionist (IP) in an office in the Ilima building on 09/06/24 at 10:35 AM. The surveyor discussed the observation on 09/03/24 when the CNA15 came out of room D2 wearing full PPE, then was observed to go into room D3 and come out with the PPE still on and then go back into room D2 then leave the room and doff PPE outside the room. The surveyor asked the IP if staff are required to change the N95 when doffing the PPE? The IP confirmed yes that the staff are required to Doff all the PPE (including the N95 mask) prior to coming out of the room. Infection Prevention and Control Program 2001 MED-PASS, Inc. (Revised August 2016) reviewed. 7. Prevention of Infection. a. Important facets of infection prevention include: (3) educating staff and ensuring that they adhere to proper techniques and procedures; .