

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

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No. 0938-0391

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 Hale Kupuna Heritage Home, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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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 (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 0689 Level of Harm - Actual harm Residents Affected - Few	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) 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] (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observations, interviews, and record review, the facility failed to ensure that its response to a Resident Council grievance was implemented and sustained in practice for one of four identified concerns. The Resident Council requested that the daily menu boards in the units be updated regularly to reflect current meal offerings. Although the facility developed action plans in response to the grievances, the facility failed to implement and sustain the interventions, resulting in menu boards that were not updated timely, or accessible to residents on a consistent basis. The deficient practice affected the resident's ability to make informed choices about their meals. Findings Include: On 03/09/26 at 10:49 AM, observed the posted daily menu in the building 1, B Wing. The breakfast and dinner menus posted were not updated. The lunch menu was not posted in the designated area but was found on a side table in front of the menu board and reflected a turkey sandwich for the previous day (03/08/26). Additionally, the A Wing did not have a menu board to post the daily menus. On 03/09/26 between 11:33 AM and 12:14 PM, multiple resident interviews (R42, R6, R21, and R4) revealed residents were unaware of the lunch meal for that day. R42 stated she was hungry and waiting for lunch but did not know what would be served, stating probably turkey something. Other residents similarly reported they did not know the meal being served. Record review of the facility's planned menu indicated lunch for 03/09/26 was meatloaf with gravy, steamed rice, mixed vegetables, and chocolate pudding. The resident council agenda and minutes for the months of November 2025, January 2026, and February 2026 were received and reviewed. Review of the minutes in November 2025 and January 2026, the resident's stated concern regarding the menu boards were not being updated regularly. In November 2025, the residents requested timely menu updates, with follow-up consultation with the Dietary Manager (DM). In January 2026, the residents reported that the menu boards continued to not be updated regularly. The facility documented a plan, from the Administrator and the DM, for nursing staff to update menu boards the night prior and indicated that nursing staff had been educated. On 03/11/26 at 11:06 AM, during a group interview with Resident Council members (R46, R5, R1, R4, R21, and R7), the residents reported the menu boards continued to not be updated. R5 stated, sometimes it's changed and sometimes it's not. R46 reported needing to hound staff to update the menu boards. R46 stated she had suggested the facility do it the night before. The residents said when the menus were not posted, they had to ask the staff what was going to be served, and not all of the residents were able to ask. On 03/11/26 at 12:16 PM, an interview was conducted with R4 who reported that staff do not inform her of the daily menu. She stated she is aware of a daily menu board located in B Wing; however, she rarely goes to that area (R4's room is in A Wing) and therefore does not check it. On 03/11/26 at 12:29 PM, an interview was conducted with R40. R40 stated he was unaware of what was being served for lunch and typically finds out when the meal is provided. He reported that if he does not like the meal, he may choose not to eat it and instead request an alternative. R40 stated that the facility sometimes provides a weekly menu but assumes residents can read it. During the interview, R40 looked around his room to see if he had received a weekly menu but was unable to locate one. He also reported that a menu is posted in B Wing, however, he does not go to that area to review it (R40's room is in A Wing). On 03/12/26 at 08:37 AM, observation revealed the menu boards in Building 1, B wing, were not updated, displaying menus from the day before on 03/11/26. On 03/12/26 at 09:03 AM, an observation was conducted in Building 2. A menu board was observed in C Wing for posting daily menus, however, no menu board was observed in D Wing for posting daily menus. On 03/12/26 at 09:08 AM, an interview was conducted with Registered Nurse (RN) 11. RN11 reported she updated the menu board in Building 2 early that morning after noticing it had not been done. RN11 stated that dietary staff are responsible for posting the daily menus. On 03/12/26 at 09:56 AM, an interview was conducted with the Social Worker (SW). The SW stated that when residents express concerns during Resident Council, she documents them in the meeting minutes and initiates a grievance. SW reported she has created grievances regarding menu (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	boards not being updated regularly in the buildings. SW emphasized the importance of residents knowing the daily menu, stating it is a resident right and that she would also want to know what meals are being served in advance. On 03/12/26 at 10:24 AM, an interview was conducted with the Administrator. The Administrator stated he had issued a directive for nursing staff to update menu boards the night before. When asked whether there was documentation confirming that nursing staff received this directive, the Administrator stated that directives are typically not documented. Review of a grievance form dated 11/18/25 documented that R46 reported during a Resident Council meeting that menu boards were not being updated. R46 requested that menus be posted the day before so residents would know the meals in advance. The facility's action plan indicated dietary staff would update menus and that menu boards would be posted on both wings of each building. Review of a grievance form dated 01/20/26 revealed that during a Resident Council meeting, R46 again reported that menu boards in the buildings were not being updated regularly. The facility's action plan stated the Administrator would work with nursing staff to ensure menu boards are updated the night before for the following day. The Dietary Manager was also noted to be aware to ensure accurate menus are available for posting. Staff were unable to identify whose responsibility it is to update the daily menu boards or demonstrate awareness of the Administrator's directive during the following interviews conducted on 03/12/26: At 10:36 AM, Certified Nurse Aide (CNA) 15 stated that housekeeping staff or dietary aides were responsible. At 10:38 AM, Dietary Aide (DA) 12 stated that housekeeping staff were responsible. At 10:39 AM, Housekeeper (HK) 9 did not respond when asked; DA12 interjected and stated the Housekeeping Manager (HKM) was responsible. At 10:41 AM, HKM stated dietary staff are responsible for updating menu boards, but she occasionally assists if it is not completed. At 10:50 AM, the Dietary Manager (DM) stated she prints the daily menus and is responsible for posting them in the buildings. DM acknowledged that the menu board in Building 1 was not updated timely on 03/12/26. At 10:54 AM, during a follow-up interview, RN11 confirmed that dietary staff, not nursing staff, are responsible for posting daily menus in the buildings.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, interviews and record reviews, the facility failed to assure that there were sufficient numbers of qualified nursing staff available in areas of the facility where vulnerable residents with high fall risk reside, to provide the supervision needed to promote safety and prevent unwitnessed falls for two of three residents (Resident (R) 7 and R54) sampled for Accident Hazards/Supervision/Devices and sufficient nurse staffing. The deficient practice resulted in pain, hospitalization and decline in function due to injuries that resulted from the falls. Cross reference to F689 Free of Accident Hazards/Supervision/Devices. Findings include: Observation on 03/09/26 at 08:45 AM. The facility has two buildings (1 and 2) each with two wings where the Residents reside. (A & B and C & D).R54 had an unwitnessed fall on the B wing 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. The daily schedule assignments for Friday 02/06/26, were reviewed. One licensed nurse worked from 06:30 AM to 7:00 PM in building 1 (covering both the A & B wings); and one Certified Nurse Aide (CNA) worked from 06:00 AM to 2:30 PM on the B wing at the time of R54's fall. One charge nurse and one CNA was assigned to float between buildings 1 and 2. It was reported by staff during a confidential interview that there was no nursing staff present on the B wing at the time of R54s fall. The kitchen dining staff found R54 lying on the floor and informed the nursing staff about the fall. Cross reference to F689.R7 had an unwitnessed fall in the bathroom on 03/07/26, that resulted in a head injury and transfer to the ER for evaluation and treatment. Cross reference to F689. The daily schedule assignments for Saturday 03/07/26, were reviewed. One licensed nurse worked from 06:30 AM to 7:00 PM in building 2 (covering both the C & D wings); and one CNA worked from 06:00 AM to 2:30 PM on the C wing at the time of R7's fall. One CNA was assigned to float between buildings 1 and 2. Total CNAs per wing was 1.5. Random observations in the two buildings on 03/09/26; 03/10/26; 03/11/26 in the morning and afternoons. Observed one or fewer staff and residents present on A & D wings. Observed increased resident activity on the B & C wings.R29 was interviewed on 03/09/26 at 10:37 AM and stated sometimes it takes a long time for staff to come answer the call light, especially when I have to use the bathroom. If I use call light it might take 20 minutes or more. When I'm out in the activity area staff aren't around so I need to use the bell or wait for them to come around. During a Resident Council meeting on 03/11/26 at 11:06 AM, R7 said he fell down on Saturday and had to yell for help. He said at the time it took 10 to 15 minutes for someone to come to help. Another resident added that she heard R7 yelling from the bathroom and had to go find someone to help him. There was no nursing staff immediately available to help him. Payroll Based Journal (PBJ) Data Report CASPER Report 1705D FY quarter 1 2026 October 1 - December 31 reviewed on 03/09/26. Metric: Excessively Low Weekend Staffing result: Triggered. Definition: Triggered = submitted weekend staffing data is excessively low.Facility Assessment approved dated 03/02/26 reviewed on 03/11/26. Services and care we offer based on our residents' needs .Mobility and Fall Prevention. Specific Care or Practices: Monitoring and Supervision .Enhanced supervision protocols are implemented for residents identified as high risk, particularly during shift changes, toileting, or nighttime hours.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to serve food at a preferable temperature for one lunch tray sampled. The foods that were to be kept cold were not served at the preferred temperature of 40 degrees Fahrenheit. The deficient practice may affect good nutrition and hydration status to help prevent, or aid in the recovery from, illness or injury. Findings include: Observation and interview with Resident (R) 7 on 03/09/26 at 10:30 AM. Asked how the food at the facility was. R7 replied, that some dishes are better than others. It, depends. A lot of the time the food tastes bland. Observation and interview with R5 on 03/09/26 at 12:05 PM. When asked how the food was, R5 said, the food is bland and sometimes the food is late. Observation and interview with R25 on 03/09/26 at 12:32 PM. R25 said the food sucks. It doesn't have any taste. The meatloaf is good but the fish and the chicken sucks. A test tray from the tray line was requested on 03/11/26 at 12:15 PM to taste the food and check the temperatures. Temperatures of the foods on the tray were checked with Dietary Aide (DA)12. The beets and mayonnaise salad temperature was checked at 69 degrees. DA12 said that it should be served at a temperature of 40 degrees Fahrenheit. A second container of the beets and Mayonnaise were checked at 69 degrees Fahrenheit. Discussed the temperature of the beets and mayonnaise salad with [NAME] (7) on 03/11/26 at 1:45 PM. She explained that she prepared the beets and mayonnaise and kept them in the cooler and thought maybe they became too warm while inside the warmer with the other trays when transported to the unit for the lunch distribution.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview, and policy review, the facility stored items in the walk-in refrigerator that were past the expired date; an open container was not labeled with an open or expiration date. The deficient practice placed residents at risk for foodborne illness. Findings include: Brief tour of the kitchen on 03/09/26 at approximately 09:15 AM. In the walk-in refrigerator, observed a clear plastic container of hot dogs with a prep date of 03/02/26 and an expiration date of 03/08/26 and an open container of yogurt about 1/3 full without a label. Interviewed the cook (5) at 09:25 AM. Asked the cook5 to verify the items found in the walk-in refrigerator to determine if they were expired. The cook5 pulled the hot dogs and the yogurt from the walk-in and discarded them saying they should have been thrown away. Observation in the walk-in refrigerator on 03/11/26 at 11:15 PM revealed a clear container of mayonnaise labeled with an expiration date of 03/09/26. Asked the Dietary Aide (DA) 2 to check the expiration date. Verified with DA2 the mayonnaise had expired on 03/09/26. The DA2 removed it from the walk-in refrigerator and discarded it. The Dietary Manager (DM) was interviewed on 03/11/26 at 11:35 AM in the kitchen. Discussed the findings in the walk-in refrigerator on 03/09/26 during the brief initial tour with Cook5. The hot dogs that were expired in the walk-in and the open container of yogurt didn't have a date and opened. Confirmed the findings in the kitchen with the Food Service Director (FSD) on 03/11/26 at 11:40 AM. Food and Nutrition Policy dated 10/01/24 was reviewed. Food Storage and Labeling Policy stated it is the policy of the facility that all food and non-food items shall be stored separately and appropriately to provide product integrity and safety. Food items shall be properly labeled and dated. Procedures: The Director/Manager of food & nutrition is responsible to 4. d. Refrigerators, reach-in coolers, and walk in coolers iv. Review inventory weekly and as needed and discard old foods. Foods opened have a use by date and must be identified. If not in packaging that identifies a use by date.		

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

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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 Hale Kupuna Heritage Home, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure the staff followed infection control and prevention measures while providing care for residents. Staff observed not performing hand hygiene as meals were being served to seven residents. This deficient practice placed the residents at risk for the potential spread of preventable infections and other adverse health complications. Findings Include: On 03/09/26 at 12:03 PM, observed Dietary Staff (DS) 3 bring the meal cart to the unit. Seven residents were in the common area and were waiting for their lunch. DS3 opened the cart and pulled out a tray with the residents' meals. After placing all the food items and drinks on the table in front of the residents, DS3 went back to the cart and immediately pulled another tray for the next resident. DS3 was not observed performing hand hygiene as he served lunch for all seven residents in the common area. Review of facility policy titled Meal Service with an effective date of 01/05/26 reviewed. The policy stated, . Prepare the room or serving area for mealtime . and provide hand hygiene as appropriate . On 03/11/26 at 01:53 PM, an interview was conducted with the Infection Preventionist (IP) in her office. Shared with IP the observations made of DS3 not performing hand hygiene as he passed the meals for seven residents on 03/09/26. IP confirmed that staff are to perform hand hygiene when moving from one resident to another to prevent possible spread of infections.		

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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 record review and interview, the facility failed to provide proper notification of transfer/discharge for one of three residents sampled for closed records review. The facility did not send written notification to the office of the State Long Term Care Ombudsman (LTCO) when Resident (R) 53 was discharged . This deficient practice has the potential to affect all residents at the facility who are discharged or transferred. Findings Include:R53 was a [AGE] year-old resident admitted to the facility for short-term rehabilitation services following the removal of internal fixation device (metal implant used to stabilize broken bones). Diagnoses included but not limited to acute osteomyelitis and infection and inflammatory reaction due to internal right hip prosthesis. Review of Electronic Health Records (EHR) under Progress Notes revealed that R53 was discharged and placed under the custody of the police department on 11/05/25 for an out-of-state warrant of arrest. No documentation was found in the EHR of the facility notification to the LTCO. On 03/12/26 at 10:27 AM, an interview was conducted with the Regional Director of Operations (RDO) who was serving as the Administrator for the facility at the time R53 was discharged . RDO confirmed that the office of the State LTCO was not notified of R53's discharge from the facility.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility inaccurately coded that a resident was taking an insulin injection; however, the resident was taking a weekly injection (Mounjaro), used to improve blood sugar control in patients with type two diabetes. The assessment portrays an inaccurate picture of the resident's status during the observation period of the minimum data set (MDS). Findings include: Electronic Health Record (EHR) reviewed on 03/09/2026. R7 is a [AGE] year-old male. Diagnosis includes Type 2 Diabetes Mellitus with hyperglycemia. Orders reviewed. Mounjaro Subcutaneous solution auto injector 5 milligrams (mg) per /0.5 milliliters (ML) Tirzepatide Inject 5 mg. subcutaneously in the morning every Monday for Diabetes Mellitus (DM). Started on 11/10/25. Insulin was not ordered for R7. Minimum Data Set (MDS) quarterly assessment, with an assessment reference date (ARD) of 01/06/26 reviewed. Section N Medications. N0350. Insulin. A. Record the number of days that insulin injections were received during the last 7 days or since admission/ entry or reentry if less than 7 days. Had insulin injection 1 day. B. Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/ entry or reentry if less than 7 days. Had orders for insulin 0 days. The MDS coordinator (MDSC) 10 interviewed by telephone on 03/11/26. Explained the findings on the MDS quarterly assessment for R7 and asked the MDSC10 if the insulin injection was coded in error. MDSC10 said the MDSC15 completed the assessment for R7 and may have been confused between the hyperglycemic and the insulin injection. MDSC15 interviewed by telephone on 03/11/2026 at 10:07 AM. Explained that R7 is not on insulin injection, but Mounjaro and asked if it was a coding error. The MDSC15 said he doesn't usually code Mounjaro as an insulin injection, but that he would check the EHR and inquire if it was incorrectly coded.		

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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 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.		