Hawaii Dept. of Health, Office of Health Care Assurance

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 _____	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE KUPUNA HERITAGE HOME, LLC	4297A OMAO ROAD KOLOA, HI 96756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	Initial Comments A re-licensure survey was conducted from 08/30/22 to 09/02/22. The facility census included 45 residents.	4 000		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to 1) perform hand hygiene during food distribution for residents on the Makalapua Nursing Unit, and 2) remove scooper from a container of thickener. As a result of this deficiency, the facility put all residents at risk for the potential for acquiring food-borne illness. Findings include: 1) During an observation of lunch preparation, on 09/30/22 at 12:30 PM, for the Makalapua Nursing Unit, Nursing Assistant (NA)1 was noted to be assisting with the tray line with no hand hygiene before, after, or throughout the preparation. NA1 was gathering utensils, wrapping them in a cloth napkin, placing them on each tray. NA1 was also pouring drinks in cups and placing them on each	4 159	1. Staff involved in the meal service were in-serviced by DON on hand hygiene. Thickener was replaced with labeled container. Staff were inserviced regarding not leaving scoops in containers. Inservices will be ongoing. 2. Facility residents have the potential to be affected by the alleged practices. 3. Licensed and non-licensed direct care staff were inserviced regarding hand hygiene while serving meals, labeling containers and not leaving scoops in containers. Inservices will be ongoing. 4. DON will audit hand hygiene during meal pass and thickener containers for labels and scoops through observation 3 x weekly for a minimum of 12 weeks or until compliance is achieved. Results of audits	10/17/22

Office of Health Care Assurance

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4 159	Continued From page 1 resident's tray Observation on 09/01/22 at 10:00 AM, NA1 distributed lunch trays to two rooms on the Makalapua Nursing Unit with no hand hygiene before, after, or in between the rooms. During staff interview on 09/01/22 at 12:40 PM, Director of Nursing (DON) acknowledged that hand hygiene should have been done during the lunch preparation and lunch distribution as previously mentioned. 2) On 08/30/22 at 09:22 AM, conducted an initial observation of the kitchen with the Kitchen Manager (KM)1. Observed scooper stored in a clear plastic container of thickener on the kitchen counter. KM1 confirmed they had just used the thickener and it should not have been left in the container. KM1 stated the scooper should be washed after use.	4 159	will be brought to QAPI monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to implement a comprehensive care plan for one resident (Resident (R)45) sampled. As a result of this deficiency, R45 was not provided with the	4 174	1. Resident 45's care plan was updated to reflect her activity preferences. DON in-serviced Interdisciplinary Team regarding comprehensive care planning including activity preferences. Inservices	10/17/22

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4 174	Continued From page 2 activities documented on her comprehensive care plan as needed to help maintain her quality of life and level of function. Findings include: Observations were made of R45 seated at a table near the unit nurse's desk on 08/30/22 at 01:15 PM, 01:45 PM, and 02:10 PM; 08/31/22 at 01:05 PM and 01:45 PM; and 09/01/22 at 01:30 PM and 02:13 PM. R45 was seated at the table, alone, and not engaged in activities or with any type of self-directed activity to do. Multiple staff walked back and forth near R45, but did not stop to provide or assist the resident with an activity. On 09/02/22 at 10:24 AM, conducted a record review of R45's Electronic Medical Record (EMR). Review of the resident's comprehensive Care Plan (CP) related to activities, documented that R45 needs memory/cognitive, sensory, and psychological stimulation to maintain her quality of life and level of function. Review of the approaches (interventions) includes providing a baby doll when out of bed, listening to Hawaiian music, and providing her with tools and materials for self-directing activities during visits such as coloring materials, magazines, and puzzles (appropriate to her level of function). These approaches were not provided to R45 during this surveyor's observations. Additionally, the comprehensive CP identified that during R45's Annual assessment on 08/3/2022, R45 stated that her favorite activity is coloring, puzzles, listening to Hawaiian music, and holding her baby doll. On 09/02/22 at 11:00 AM, conducted an interview and concurrent record review with the Activities Manager (AM). AM confirmed R45 should be	4 174	will be ongoing as needed. 2. Facility residents have the potential to be affected by the alleged practice. 3. Licensed nurses, activities staff, IDT were inserviced regarding comprehensive care planning including activity preferences. Inservices will be ongoing as needed. 4. DON will audit resident care plans for comprehensive care planning including activity preferences weekly for a minimum of 12 weeks or until compliance is achieved. Results of audits will be brought to QAPI monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	

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4 174	Continued From page 3 engaged in an activity, baby doll or puzzles, while seated at the table near the nurse's desk and not just sitting there watching staff walk by.	4 174		
4 194	11-94.1-46(k) Pharmaceutical services (k) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. This Statute is not met as evidenced by: Based on observation, interviews, and a review of facility policy, the facility failed to lock one (1) medication cart on the Mokihana Nursing Unit. Proper storage and labeling of medications is necessary to promote safe administration practices, and to decrease the risk of medication errors and diversion of resident medications. This deficient practice has the potential to affect all residents in the facility. Findings Include: On 09/01/22 at 08:58 AM, a medication cart was observed in the Mokihana nursing unit. The medication cart was unlocked and located approximately 10-15 feet away from the communal dining area. Resident (R) 25 whom is able to self-propel herself in a wheelchair, was in the dining area. Nurse (N) 2 was observed at the nurses' station down the hall talking to another staff member. The surveyor went to the medication cart and opened and closed the medication drawer. Immediately after the surveyor closed the medication drawer, N2 walked from the nurses' station and locked the medication cart. When asked if the medication cart should be locked, N2 stated that the	4 194	1. Medication cart was secured and licensed nurse involved was reinserviced regarding securing the medication cart by the DON/designee. 2. Facility residents have the potential to be affected by the alleged practice. 3. Licensed nurses were inserviced regarding securing the medication cart by the DON. Inservices will be ongoing as needed. 4. DON will audit medication cart security through observation 3 x weekly for a minimum of 12 weeks or until compliance is achieved. Results of audits will be brought to QAPI monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	10/17/22

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4 194	Continued From page 4 medication cart should be locked and that she forgot to lock the cart because she was distracted by giving shift report to another staff member. On 09/02/22 at 12:24 PM. The Director of Nursing (DON) and the Resource Director of Nursing (RDON) was interviewed. The DON and RDON confirmed that medication carts should be locked if staff are not accessing medications. The DON confirmed that N2 should have locked the medication cart before leaving it unattended. On 09/02/22 at 01:00 PM, the facility's policy, "Section 4.1 Storage of Medication" dated 01/21 was reviewed. The policy stated, "Procedures ...3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended by persons with authorized access."	4 194		

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E 000	Initial Comments The facility was found in compliance with Health Section 483.73, Requirement for Long-Term Care (LTC) Facilities of Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual.	E 000		

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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.

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F 000	INITIAL COMMENTS A re-certification survey was conducted by the Office of Health Care Assurance (OHCA) on 08/30/2022 - 09/02/2022. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. ACTS #9439, #9576, and #9702 were investigated and not substantiated. Survey Dates: 08/30/2022 - 09/02/2022 Survey Census: 45 Sample Size: 12	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		10/17/22

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F 584	Continued From page 1 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and an interview, the facility served meals on trays during mealtime and did not remove the trays for 2 residents (Resident (R)34 and R46) sampled. As a result of this deficiency, the facility failed to provide the resident's right to a homelike environment. Findings include: On 08/30/22 at 12:30 PM, observed R34 and R46 seated at two separate tables on the A side of the Mokihana Nursing Unit during lunch. R34 and R46's lunchtime meals remained on the delivery tray for the entirety of the meal. On 08/31/22 at 10:15 AM, conducted a review of R34's and R46's Electronic Medical Record	F 584	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Resident 34 and 46 meals are being removed from the trays and served off the tray on the table. Staff involved in incident have been re-inserviced regarding meal service by the DON. 2. Facility residents have the potential to	

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F 584	Continued From page 2 (EMR). There was no documentation that confirmed it was the preference of both residents to eat their meals on trays. On 09/02/22 at 11:15 AM, during an interview with the Director of Nursing (DON), it was confirmed that R34's and R46's lunchtime meal should have been removed from the delivery tray for a more homelike environment during meals.	F 584	be affected by the alleged practice. 3. Direct care staff and dietary staff were inserviced regarding removing dishes and meal service pieces from tray and placing them on the tables by the DON. Inservices will be ongoing as needed. 4. DON will monitor compliance through observations on rounds 3 x weekly for a minimum of 12 weeks or until compliance is achieved. Results of observation audits will be brought to QAPI monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free	F 604		10/17/22

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F 604	Continued From page 3 from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility used a repositioning wedge cushion as a physical restraint for Resident (R) 29. As a result of this deficiency, the facility failed to ensure R29's right to be free from any physical restraints that are not required to treat the resident's medical symptoms or for staff convenience. Findings include: An observation on 08/31/22 at 11:41 AM, was made of Resident (R)29 lying in bed, eyes closed, and appeared to be sleeping. The left-side of R29's bed was placed up against the wall, enabler bars were up (no padding on bars) on both sides of the bed, and a long repositioning wedge cushion was placed on the right-side of the bed. The repositioning wedge cushion was positioned along the right edge of the bed and extended from the bottom of the right enabler bar straight down to the foot of the bed. R29 was blocked in on all four sides of the bed. R29 laid on his left shoulder facing the wall and was positioned close to the wall. From the position R29 was laying in, it did not appear that the resident needed assistance with turning from side to side (for repositioning) in the bed. The wedge cushion was not placed under the resident's body	F 604	1. Resident 29 was re-evaluated for positioning and fall interventions by therapy and the Interdisciplinary Team. Enabler bars were padded for resident's protection. Interventions were put in place as needed. 2. Facility residents have the potential to be affected by the alleged practice. 3. Direct care staff were inserviced regarding appropriate positioning and fall interventions by the DON. Inservices will be ongoing as needed. 4. DON will monitor compliance through observations on rounds 3 x weekly for a minimum of 12 weeks or until compliance is achieved. Results of observation audits will be brought to QAPI monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	

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F 604	Continued From page 4	F 604		

aiding in repositioning, instead, it blocked the side of the bed that R29 could exit the bed.

On 09/01/22 at 09:15 AM, a second observation was made of R29. The observation documented the same placement of the resident's bed, body position, and position of the wedge cushion. Again, the wedge cushion was not placed under the resident's body to assist with repositioning. The wedge cushion blocked the portion of the bed where the resident would be able to transfer himself off of the bed.

Conducted an interview with Nurse Manager (NM)4 on 09/01/22 at 10:15 AM regarding the use of the repositioning cushion. NM4 stated the resident is confused and has fallen when attempting to get out of bed. NM4 stated R29 requires the use of the repositioning wedge cushion for off-loading pressure, requires assistance with turning in bed, and cannot turn himself in bed. NM4 stated R29 will use the enabler bars to assist staff with repositioning, and the repositioning wedge cushion protects R29 from hitting the enabler bars. Shared this surveyor's observation of R29 on 08/31/22 and 09/01/22 during which the wedge cushion was not placed under the resident but was observed to be obstructing the resident from getting up out of bed. NM4 did not reply to this surveyor's observation of R29 on 08/31/22 and 09/01/22.

On 09/01/22 at 09:42 AM, conducted a record review of R29's Electronic Medical Record (EMR). Review of the resident's progress note documented on 04/26/22, R29 had an unwitnessed fall in the room, R29 stated he was tired and attempted to self-transfer (from the wheelchair) to bed without using the call light.

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The wheel of the wheelchair was not locked and contributed to the resident falling.

In progress notes written on 05/04/22 at 06:21 PM, documented R29's increased confusion, an increase in his attempts to self-transfer, and falls. Another progress note written on 05/10/22 at 07:27 AM, documented R29 was attempting to get out of bed multiple times by himself, appears to be confused. He was seen by staff standing beside his bed alone (unsupervised). R29 was observed wheeling himself in and out of his room multiple times and the resident was awake most of the night.

Review of R29's comprehensive Care Plan (CP) (last reviewed/revised on 08/16/22 at 11:18 AM by NM4), documented R29 is at risk for skin breakdown, injury, and bruising related to fragile skin, self-inflicted bruising, observed restlessness and fidgety behavior at night and occasionally observed hitting his own legs and shaking enabler bars at night. Approaches (interventions) include the use of pillows as barriers to the enabler bars (to reduce injury from resident hitting the enabler bars), but do not include the use of a repositioning wedge cushion. Review of R29's entire comprehensive CP does not include documentation for the use of a repositioning wedge as an approach (intervention) for an identified issue.

On 09/02/22 at 11:19 AM, conducted an interview with the Director of Nursing (DON) regarding the observation of the use of the wedge and a restraint for R29. DON stated although R29 has left-sided weakness, he does have the muscle strength, can turn himself in bed (from side-to-side) and can pull himself up. DON

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 6 confirmed R29 can roll from side to side (by himself) in bed, does not need to use a repositioning wedge cushion for off-loading or repositioning, and R29 often ends up sitting at the side of the bed (unsupervised).	F 604		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of	F 623		10/17/22

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	125062	A. BUILDING _____ B. WING _____	09/02/2022

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F 623	Continued From page 7	F 623		

this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and

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F 623	Continued From page 8 email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure transfer notices were sent out to the resident's representative (RR) and the Ombudsman in a timely manner for one resident (Resident (R)29) sampled. This deficiency has the potential to affect all residents who are transferred from the facility. Findings include: On 09/01/22 at 09:42 AM, conducted a review of R29's Electronic Medical Record (EMR). Review of the resident's census documented R29 was sent out to an acute hospital for medical attention	F 623	1. Staff involved with sending out the late notices were inserviced regarding timely notification of responsible parties and the Ombudsman's office upon discharge/transfer by the Administrator. Inservices will be ongoing as needed. 2. Facility residents, who are discharging or transferring, have the potential to be affected by the alleged practice. 3. Social Service Director and IDT were inserviced regarding timely notification of responsible parties and the Ombudsman's office upon discharge/transfer by the Administrator.	

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F 623	Continued From page 9 on 11/24/21 and 4/26/22. Review of the facility's Notice of Resident Discharge/Transfer form documented a written notification for the 11/24/21 transfer was sent out to R29's RR and the Ombudsman on 01/18/22, which was approximately two (2) months after the transfer occurred. The Notice of Resident Discharge/Transfer form for R29's 4/26/22 transfer to an acute hospital for medical attention, was sent out to R29's RR and the Ombudsman on 08/29/22, which was approximately four (4) months after the transfer occurred. The intent of sending copies of the notice to a representative of the Office of the State Long-Term Care Ombudsman is to provide added protection to residents from being inappropriately discharged, provide residents with access to an advocate who can inform them of their options and rights, and to ensure that the Office of the State Long-Term Care Ombudsman is aware of facility practices and activities related to transfers and discharges. On 09/01/22 at 10:00 AM, requested to interview staff responsible for the written notice of a resident's transfer or discharge. The responsible staff was not available for an interview.	F 623	Inservices will be ongoing as needed. 4. Administrator will monitor compliance through medical record audits weekly for a minimum of 12 weeks or until compliance is achieved. Results of audits will be brought to QAPI monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		10/17/22

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F 656	Continued From page 10 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to implement a comprehensive care plan for one resident (Resident (R)45) sampled. As a result of this deficiency, R45 was not provided with the activities documented on her comprehensive care	F 656	1. Resident 45's care plan was updated to reflect her activity preferences. DON/designee inserviced Interdisciplinary Team regarding comprehensive care planning including activity preferences. Inservices will be ongoing as needed.	

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F 656	Continued From page 11 plan as needed to help maintain her quality of life and level of function. Findings include: Observations were made of R45 seated at a table near the unit nurse's desk on 08/30/22 at 01:15 PM, 01:45 PM, and 02:10 PM; 08/31/22 at 01:05 PM and 01:45 PM; and 09/01/22 at 01:30 PM and 02:13 PM. R45 was seated at the table, alone, and not engaged in activities or with any type of self-directed activity to do. Multiple staff walked back and forth near R45, but did not stop to provide or assist the resident with an activity. On 09/02/22 at 10:24 AM, conducted a record review of R45's Electronic Medical Record (EMR). Review of the resident's comprehensive Care Plan (CP) related to activities, documented that R45 needs memory/cognitive, sensory, and psychological stimulation to maintain her quality of life and level of function. Review of the approaches (interventions) includes providing a baby doll when out of bed, listening to Hawaiian music, and providing her with tools and materials for self-directing activities during visits such as coloring materials, magazines, and puzzles (appropriate to her level of function). These approaches were not provided to R45 during this surveyor's observations. Additionally, the comprehensive CP identified that during R45's Annual assessment on 08/3/2022, R45 stated that her favorite activity is coloring, puzzles, listening to Hawaiian music, and holding her baby doll. On 09/02/22 at 11:00 AM, conducted an interview and concurrent record review with the Activities Manager (AM). AM confirmed R45 should be	F 656	2. Facility residents have the potential to be affected by the alleged practice. 3. Licensed nurses, activities staff, IDT were inserviced regarding comprehensive care planning including activity preferences. Inservices will be ongoing as needed. 4. DON will audit resident care plans for comprehensive care planning including activity preferences weekly for a minimum of 12 weeks or until compliance is achieved. Results of audits will be brought to QAPI monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	

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F 656	Continued From page 12 engaged in an activity, baby doll or puzzles, while seated at the table near the nurse's desk and not just sitting there watching staff walk by.	F 656		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and a review of facility policy, the facility failed to lock one (1) medication cart on the Mokihana Nursing Unit. Proper storage and labeling of medications is necessary to promote safe administration	F 761	1. Medication cart was secured, and licensed nurse involved was reinserviced regarding securing the medication cart by the DON. 2. Facility residents have the potential to	10/17/22

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F 761	Continued From page 13 practices, and to decrease the risk of medication errors and diversion of resident medications. This deficient practice has the potential to affect all residents in the facility. Findings Include: On 09/01/22 at 08:58 AM, a medication cart was observed in the Mokihana Nursing Unit. The medication cart was unlocked and located approximately 10-15 feet away from the communal dining area. Resident (R) 25 whom is able to self-propel herself in a wheelchair, was in the dining area. Nurse (N) 2 was observed at the nurses' station down the hall talking to another staff member. The surveyor went to the medication cart and opened and closed the medication drawer. Immediately after the surveyor closed the medication drawer, N2 walked from the nurses' station and locked the medication cart. When asked if the medication cart should be locked, N2 stated that the medication cart should be locked and that she forgot to lock the cart because she was distracted by giving shift report to another staff member.On 09/02/22 at 12:24 PM. The Director of Nursing (DON) and the Resource Director of Nursing (RDON) was interviewed. The DON and RDON confirmed that medication carts should be locked if staff are not accessing medications. The DON confirmed that N2 should have locked the medication cart before leaving it unattended. On 09/02/22 at 01:00 PM, the facility's policy, "Section 4.1 Storage of Medication" dated 01/21 was reviewed. The policy stated, "Procedures ...3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer	F 761	be affected by the alleged practice. 3. Licensed nurses were inserviced regarding securing the medication cart by the DON. Inservices will be ongoing as needed. 4. DON will audit medication cart security through observation 3 x weekly for a minimum of 12 weeks or until compliance is achieved. Results of audits will be brought to QAPI monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	

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F 761	Continued From page 14 medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended by persons with authorized access."	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to 1) perform hand hygiene during food distribution for residents on the Makalapua Nursing Unit, and 2) remove scooper from a container of thickener and label container with contents. As a result of this deficiency, the facility put all residents at risk for the potential for acquiring food-borne illness.	F 812	1. Staff involved in the meal service were in serviced by DON on hand hygiene. Thickener was replaced with labeled container. Staff were inserviced regarding not leaving scoops in containers. Inservices will be ongoing. 2. Facility residents have the potential to be affected by the alleged practices. 3. Licensed and non-licensed direct care	10/17/22

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F 812	Continued From page 15 Findings include: 1) During an observation of lunch preparation, on 09/30/22 at 12:30 PM, for the Makalapua Nursing Unit, Nursing Assistant (NA)1 was noted to be assisting with the tray line with no hand hygiene before, after, or throughout the preparation. NA1 was gathering utensils, wrapping them in a cloth napkin, placing them on each tray. NA1 was also pouring drinks in cups and placing them on each resident's tray Observation on 09/01/22 at 10:00 AM, NA1 distributed lunch trays to two rooms on the Makalapua Nursing Unit with no hand hygiene before, after, or in between the rooms. During staff interview on 09/01/22 at 12:40 PM, Director of Nursing (DON) acknowledged that hand hygiene should have been done during the lunch preparation and lunch distribution as previously mentioned. 2) On 08/30/22 at 09:22 AM, conducted an initial observation of the kitchen with the Kitchen Manager (KM)1. Observed scooper stored in a clear plastic container of thickener on the kitchen counter. KM1 confirmed they had just used the thickener and it should not have been left in the container. KM1 stated the scooper should be washed after use.	F 812	staff were inserviced regarding hand hygiene while serving meals, labeling containers and not leaving scoops in containers. Inservices will be ongoing. 4. DON will audit hand hygiene during meal pass and thickener containers for labels and scoops through observation 3 x weekly for a minimum of 12 weeks or until compliance is achieved. Results of audits will be brought to QAPI monthly for review and recommendations for a minimum of 3 months or until compliance is achieved.	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents	F 838		10/17/22

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F 838	Continued From page 16 competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both	F 838		

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F 838	Continued From page 17 employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Facility Assessment included an evaluation of the overall number of facility staff needed to ensure sufficient number of qualified staff are available to meet each resident's needs. This deficiency has the potential to put residents at risk for harm. Findings include: On 09/02/22 at 11:05 AM, reviewed the facility assessment that was provided to the survey team on 08/30/22. Review of the facility assessment documented in Section A.1. Function- Sufficiency Analysis Summary, considerations for staffing and scheduling systems identified smartlinx for appropriate staffing levels for the census and that the facility ensures one RN (registered nurse) on staff at all times. However, there is no indication of the overall number of staffing needed to meet the residents' needs.	F 838	1. The Director of Operations in-serviced the Administrator regarding documentation on the facility assessment regarding sufficient staffing numbers. Inservices will be ongoing as needed. The facility assessment was reviewed and updated to reflect staffing numbers to meet residents' needs. 2. Facility residents have the potential to be affected by the alleged practices. 3. The administrator in-serviced the IDT regarding the facility assessment, sufficient staffing numbers and updating of the assessment. Inservices will be ongoing as needed. 4. Administrator will audit the facility assessment for updates as needed on staffing numbers monthly for a minimum of three months or until compliance is achieved. Results of audits will be brought to QAPI monthly for review and	

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F 838	Continued From page 18 Throughout the facility assessment, the sufficiency Analysis Categories for Overall Staffing is numerically valued at 0/0 (zero/zero) and subsequent categories identified as "Sufficient" for the areas of: II. Staffing, Training, Service & Personnel; (individual categories identified as sufficient) A.1. Function- Sufficient Analysis Summary; (no insufficiencies were identified) B. Acuity- Disease, Conditions, & Treatments; (individual categories identified as sufficient) C. Cognitive, Mental, & Behavioral Status; (individual categories identified as sufficient) D. Cultural, Ethnic, & Religious Factors; (individual categories identified as sufficient) On 09/02/22 at 12:38 PM, reviewed the facility assessment with the Administrator and confirmed the facility assessment does not contain the overall number of facility staff needed to meet the resident's needs.	F 838	recommendations for a minimum of 3 months or until compliance is achieved.	

Hawaii Dept. of Health, Office of Health Care Assurance

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 _____	C 09/02/2022

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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4 000	Initial Comments A re-licensure survey was conducted from 08/30/22 to 09/02/22. The facility census included 45 residents.	4 000		

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/27/22