Hawaii Dent	of Health	Office of Health	Care Assurance

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		· · · ·	IE SURVEY MPLETED
		125046	B. WING		0	8/10/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE	, ZIP CODE		
PU'UWAI '	O MAKAHA	84-390 JAI WAIANAE,	DE STREET HI 96792			
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4 000	Initial Comments		4 000			
	of Health Care Assur 2-10, 2022. The facil with Title 11 Chapter 9561, 9662 was also unsubstantiated. Survey Census: 60	was conducted by the Office ance (OHCA) on August ity was not in compliance 94.1. ACTS #9494, 9555, investigated and				
4 102	Sample Size: 24 11-94.1-22(d) Medica	I record system	4 102			9/16/22
	(d) Records to be m	aintained and updated, as ration of each resident's stay				
	(1) Appropriate for medical procedure	authorizations and consents es;				
	of use of physical or					
	(3) Copies of initial and periodic examinations and evaluations, as well as progress notes at appropriate intervals	aluations, as well as				
	setting forth goals to individually designed treatments, and indic	activities, therapies, and ating which professional is responsible for providing				
	medications, tests, in ancillary services					
BORATORY	h Care Assurance DIRECTOR'S OR PROVIDER/: cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE 09/05/22
ATE FORM			6899 XF	R111	If cont	inuation sheet 1

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Hawaii Dept.	of Health.	Office of Healt	h Care Assurance

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125046	· ,		(X3) DATE SURVE COMPLETED 08/10/20	
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NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, ST	ALE, ZIP CODE		
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4 102	Continued From page	9 1	4 102			
	APRN's orders compl	's, physician assistant's, or leted with appropriate signature, title, and date).				
	reviews, the facility fa that Resident (R) 36 v of losing consciousne a result of this deficie an increased risk for i Findings include: On 08/02/22 at 01:43	ns, interviews, and record iled to accurately document was experiencing symptoms ess in his medical record. As nt practice, R36 was put at njuries.		This plan of correction constitutes ou written allegation of compliance for the deficiencies cited. However, submiss this plan of correction is not an admiss that a deficiency exists or that one w cited correctly. This plan of correction submitted to meet requirements established by state and federal law. 1. Resident # 36 was discharged. Licensed nurses caring for resident w	ne sion of ssion as n is	
	the bed up at 45 degr was approximately ele R36's bed also had h inches in length locate	tting in bed, with the head of rees. R36's bed mattress evated 2 feet off the ground. andler bars approximately 6 ed approximately 6 inches		inserviced regarding documentation residents condition by the Staff Deve Inservices will be ongoing as needed 2. Facility residents have the potenti be affected by this alleged practice.	eloper. I.	
	oriented to person, tir questions appropriate and cloudy. He was	oth knees. He was alert and ne, and place and answered ely. His eyes appeared gray able to move his body,		3. Licensed nurses were inserviced regarding documentation of residents condition by the Staff Developer / DON/designee. Inservices will be on as needed.	going	
	that he was legally bli cardiac defibrillator. H straight on the bed ar	his bedside table. He stated nd and had an internal le then suddenly sat up nd was silent for onds. He was unresponsive		4. DON / Unit managers /designee w monitor compliance through observa on rounds and medical record review weekly for a minimum of 12 weeks o compliance is achieved. The results	tions /s r until	
	to surveyor's inquiries forcefully laid down be and turned his head t	if he was okay. He then ackwards in bed, groaned, o the right until it touched His body also shifted to right		these observation and record review audits will be brought to the monthly Quality Assurance and Performance meeting for a minimum of three month		
	side of the bed. He s then silent and unres	topped moving. He was		until compliance is achieved.		

Hawaii Dent	of Health	Office of He	alth Care Assurance

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125046	(X2) MULTIPLE CO A. BUILDING: B. WING		COM	E SURVEY PLETED
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4 102	Continued From page		4 102			
	Surveyor then left R3 (N) 3. Surveyor expla- of R36 during their int has episodes of low b toothache. At 01:44 I R36's room and found stated that he was ho pain. RN3 proceeded bed and take R36's v On 08/02/22 at 01:47 with R36 where surve happened during their remembered being in and then the next thir	PM, N3 and surveyor went to d R36's lying in bed. R36 of and dizzy and had tooth to lower R36's head of the ital signs. PM, an interview was done				
	with N3. Surveyor re become suddenly uni interview, fallen back stopped moving and answer surveyor's rep okay, and did not rem unresponsive during t	PM, an interview was done peated to N3 that R36 had responsive during their wards in bed and groaned, remained silent, did not beated questions if he was nember becoming the interview. N3 responded he and will alert the doctor.				
	was reviewed. "Prog 04:49 PM, N3 docum (02:00PM), resident of laid down in bed. He bed elevated due for VS (vital signs) collect 120/61, P (pulse) 80, (temperature) 96.7F ( (respiratory rate) 19.	AM, R36's medical record ress Note" dated 08/02/22 at ented, "At approx. 1400 complained of dizziness and ad of bed down and foot of possible low blood pressure. cted BP (blood pressure) 96% on RA (Room air), T (Fahrenheit), and RR Blood glucose 191 mg/dL. sat up in bed and HOB (head				

Hawaii Dept.	of Health.	Office of Health	Care Assurance

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4 102	Continued From page	e 3	4 102			
	minutes later resident asked for oxygen. Re shortness of breath w pain. Resident sating insisted that oxygen b on and resident sating assessed due to resid discomfort to right bar right is black in color w Resident stable with r time. MD (medical do resident tooth and ch ordered dental appoint Augmentin 500mg Bl Dental appointment o with start tonight. End was found regarding reported to N3 that R unresponsive during b	dizziness reported. About 5 t called out for this CN and esident complained of with no dizziness or chest g at 98% on RA but still by applied. Nasal cannula g 98% on 1 lpm. Mouth dent complaining of pain and ck tooth, last tooth on the with the base of tooth white. no other concerns at this botor) called and aware of ange in condition. MD ntment and to start antibiotic D (twice a day) x 2 weeks. on 08/05/22 and Augmentin dorsed." No documentation surveyor's observation 36 had become his interview with surveyor eference to F689: Accidents				
	laying in his bed with his forehead. R36 sta when he "blacked out R36 stated that his ro and that he had a bur On 08/04/22 at 09:09 being transferred to th "Progress Note" date documented that a fo the facility to R36's ca that "resident was add	AM, R36 was observed ne hospital. ed 08/05/22 at 01:48 PM, llow-up call was placed by ardiology clinic who stated mitted to hospital with tachycardia status-post fall				

## Hawaii Dept. of Health. Office of Health Care Assurance

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X3) DATE SURVEY COMPLETED
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Continued From page	9 4	4 102		
-				
11-94.1-30 Resident	care	4 136		9/16/22
procedures that addre care needs to assist to maintain the highest p medical status, include (1) Respiratory (2) Dialysis; (3) Skin care and pro- (4) Nutrition and hyde (5) Fall prevention; (6) Use of restraints (7) Communication; (8) Care that address development when the	ess all aspects of resident he resident to attain and bracticable health and ling but not limited to: care including ventilator use; evention of skin breakdown; Iration; and ses appropriate growth and le facility provides care to			
Based on observation reviews, and review of failed to ensure Resid accident hazards, 2) the lowest position re laceration to R36's he failed to collect/secure from Resident (R)17, well as all other resid hazards. Findings include: 1) On 08/03/22 at 11	ns, interviews, record of policy, the facility: 1) dent (R)26 remained free of failed to keep R36's bed in sulting in a fall and a ead that required stitches, 3) e smoking material (lighter) and as a result put R17 as ents at risk for accident :36 AM, conducted a record		in the facility. A scoop mattress was ordered to provide additional safety for resident when turning. CNAs involved in the incident were inserviced regarding turning by the Staff Developer. Residen 36 was discharged. Resident 17 s ligh was secured at the nurses station. Licensed nurses on resident s unit wer inserviced regarding the smoking policy the Staff Developer. Inservices will be ongoing as needed. 2. Facility residents have the potential be affected by this alleged practice.	t ter e by
	ROVIDER OR SUPPLIER O MAKAHA SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page at the time of fall yest he was shocked at 08 11-94.1-30 Resident of The facility shall have procedures that addre care needs to assist to maintain the highest p medical status, includ (1) Respiratory (2) Dialysis; (3) Skin care and pro- (4) Nutrition and hyc (5) Fall prevention; (6) Use of restraints (7) Communication; (8) Care that address development when the infants, children, and This Statute is not m Based on observation reviews, and review of failed to ensure Resident accident hazards, 2) the lowest position re laceration to R36's he failed to collect/secure from Resident (R)17, well as all other resident hazards. Findings include: 1) On 08/03/22 at 11	Image: Correction       Image: Correction Number:         Image: Correction       Image: Correction Number:         Image: Correction Number: Correction Correction Number: Correc	PF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:.         125046       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST/ 84.390 JADE STREET WAIANAE, HI 96792         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX PREFIX TAG         Continued From page 4       4 102         at the time of fall yesterday at 0830report shows he was shocked at 0812 and 0835."       4 136         The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: <ol> <li>Respiratory care including ventilator use;</li> <li>Skin care and prevention of skin breakdown;</li> <li>Near and prevention;</li> <li>Use of restraints;</li> <li>Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth.</li> </ol> This Statute is not met as evidenced by: Based on observations, interviews, record reviews, and review of policy, the facility: 1) failed to ensure Resident (R)26 remained free of accident hazards, 2) failed to keep R36's bed in the lowest position resulting in a fall and a laceration to R36's head that required stitches, 3) failed to collect/secure smoking material (lighter) from Resident (R)17, and as a result put R17 as well as all other residents at risk for accident hazards.         Findings include:       1) On 08/03/22 at 11:36 AM, conducted a record	PCORRECTION       IDENTIFICATION NUMBER       A. BUILDING         125046       B. WING         SOVIDER OR SUPPLIER       STREET ADORESS, CITY, STATE, ZIP CODE         O MAKAHA       84-390 JADE STREET WAIANAE, HI 95792         SUMMEY STATEMENT OF DEFICIENCY MUST GE PRECEDED BY FULL REQUINTORY OR LISC IDENTIFYING INFORMATION)       IP         REGULATORY OR LISC IDENTIFYING INFORMATION)       PREFIX TAG         PREFIX       PROVIDER'S PLAN OF CORRECTOR ATTON SHOULD BY REGULATORY OR LISC IDENTIFYING INFORMATION)         Continued From page 4 at the time of fall yesterday at 0830report shows he was shocked at 0812 and 0835."       4 136         11-94.1-30 Resident care       4 136         The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to:         (1) Respiratory care including ventilator use;       (2) Dialysis;         (3) Skin care and prevention of skin breakdown;       (4) (4) Nutrition and hydration;         (5) Fall prevention;       (2) Care that addresses appropriate growth and development when the facility: 1) failed to ensure Resident (R)26 remained free of accident hazards, 2) failed to keep R36's bed in the locidert were inserviced regarding the locidert were inserviced regarding the locident were inservice regarding the locident were inservice regarding the locident were inservice regarding the locident were inservice regarding the limitent residents at risk for accident

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#### Hawaii Dept. of Health, Office of Health Care Assurance

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	SURVEY
		125046	B. WING		08	/10/2022
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4 136	Continued From page	9 5	4 136			
	4 136 Continued From page 5 R26 was admitted with diagnosis that include chronic respiratory failure, quadriplegia, anoxic brain damage, tracheostomy, dysphagia, epilepsy, and contracture. The resident is unable to speak or move independently. On 04/26/22. R26 fell and sustained a laceration to his forehead that required stitches. A progress note documented R26 had an assisted fall onto the left side of his bed during a bed bath. Certified Nurse Aide (CNA)85 on the right side of the bed turned R26 and CNA63 (on the left side of the bed) held R26 and attempted to keep him on the bed but could not because of the resident's weight and uneven distribution of R26's body. R26 was sent out to the emergency room due to the amount of blood (coming from the injury to the resident's head).			inserviced regarding turning fall precautions and smoking Staff Developer / DON/desig Inservices will be ongoing a 4. DON / Unit managers /de monitor compliance through on rounds weekly for a minii weeks or until compliance is The results of these observa be brought to the monthly Q Assurance and Performance minimum of three months of compliance is achieved.	g policy by the gnee. s needed. esignee will observations mum of 12 s achieved. ation audits will quality e meeting for a	
	Review of the facility's Focused Clinical Event Review form documented the R26 was too heavy for CNA63 to hold and CNA85 (on the right side) was unable to help as R26 went to the floor.	nted the R26 was too heavy d CNA85 (on the right side)				
	with the Director of N R26's fall. The DON move (quadriplegic), to move, and staff wa uneven distribution of falling. Inquired and documentation of star turning R26. The DO had provided training	ursing (DON) regarding confirmed R26 is unable to is totally dependent on staff is not able to manage the f weight resulting in the R26 requested to review ff training regarding safely N stated the nurse manager				
	R36 was observed si	:43 PM, a concurrent view was done with R36. tting in bed, with the head of rees. R36's bed mattress				

Hawaii Dent of Health	, Office of Health Care Assurance

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
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4 136	Continued From page	9 6	4 136			
	was approximately el There were no fall ma also had handler bars length located approx top of the mattress. If both knees. He was time, and place and a appropriately. His ey cloudy. He was able items from his bedsid was legally blind. A review of R36's ele done on 08/03/22 at Sheet" documented t 10/12/2016 for ischer also has diagnoses of chronic kidney diseas diabetes, bipolar diso disorder, legal blindre implantable cardiac d acquired absence of below the knee. Mini Quarterly Review witt (ARD) 06/20/22 docu Mental Status score of cognitively intact. MI Section G documente one-person physical a transfers. Section H no history of falls since On 08/04/22 at 08:47	evated 2 feet off the ground. ats on the floor. R36's bed s approximately 6 inches in kimately 6 inches from the R36 had amputations below alert and oriented to person, answered questions es appeared gray and to move his body, grabbing te table. He stated that he ctronic health record was 10:00 AM. "Resident Face hat R36 was admitted on nic cardiomyopathy. He f hypertensive heart and se with heart failure, type 1 order, major depressive ess, presence of automatic lefibrillator (ICD), and both left leg and right leg mum Data Set (MDS) n assessment reference date mented a Brief Interview for of 15, meaning that R36 is DS with ARD 06/20/22, ed that R36 requires assist for bed mobility and documented that R36 has				
	his forehead. The be inches off the ground bed when he "blacker floor. R36 stated that	a rolled-up towel on top of d was observed to be 16 . R36 stated that he was in d out" and ended up on the t his roommate called staff ad a bump on his forehead.				

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4 136	Continued From page	e 7	4 136			
	On 08/04/22 at 09:09 being transferred to th	AM, R36 was observed he hospital.				
	medical record was d stated, "Resident at F impaired balance and Care Plan stated, "Ap	AM, a review of R36's lone. R36's Care Plan Risk for falling related to d use of antidepressant." The oproach Start Date: ed in lowest position with				
	and observation was Assistant (CNA) 1. C feeding another resid R36's room because that Nurse (N) 3 was ground. CNA1 stated when she entered R3 2 feet high. CNA1 stated	AM, a concurrent interview done with Certified Nursing CNA 1 stated that she was ent when she was called to he had fallen. CNA1 stated there and R36 was on the d that the height of R36's bed 36's room was approximately ated the bed was then hsferred him from the ground				
	and observation was N3 stated that this mo R36's roommate that in their room. N3 state room and found R36 the left side of the be- lying down on his righ able to talk and that h of his forehead. N3 st for help. N3 stated th the ground when she the staff lowered the	AM, a concurrent interview done with N3 in R36's room. brining she was alerted by something was happening ed she went to check R36's on the ground. R36 was on d on the ground and was ht side. N3 stated he was he had a bump in the middle stated that she called CNA1 hat R36's bed was higher off found R36 and that one of bed afterwards. N3 R36's room and confirmed				
	that R36's bed was n inches off the floor) a	ow in the lowest position (16 nd that R36's bed was s when she found R36 on the				

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4 136	Continued From page	28	4 136			
	floor. When asked al stated to keep bed in stated that R36's bed inches off the floor ar than 16 inches. N3 st whether R36 was edu the lowest position.	bout R36's care plan that the lowest position, N3 is usually higher than 16 ad that he prefers it higher ated that she was not sure ucated on keeping his bed in				
	care plan and confirm documented to keep with breaks locked. F	wed. RCM reviewed R36's ned that the care plan bed in the lowest position RCM stated that there is no height is the standard for				
	08/04/22 was reviewed that R36 had a fall at stated "I don't know. I next thing I know I he floorMy head kind stated "Resident repor Red lump to middle o Report Witness State stated that R36 was e of the fall and that pri attempt to get out of I the question "Did the	AM, "Incident Report" dated ed. "Incident Report" stated 08:30 AM and that resident was on the bed and the ard you and I was on the of hurts." "Incident Report" orted hitting head on floor. f forehead. Ice." "Incident ment" dated 08/04/22 by N3 eating breakfast at the time or to the fall resident did not bed. N3 also stated "No" to resident have safety ats, alarms, low bed) at the				
	review and observation Director of Nursing. If Hopkins Fall Risk Ass 06/14/22 and confirm score of 9 points mean "Moderate Fall Risk".	DON reviewed "Johns sessment Tool" dated ed that R36 had a fall risk uning that R36 had a				

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4 136	Continued From page	9	4 136			
	have the bed in the lo	west position. DON then				
	observed R36's bed i	-				
		utton to lower R36's bed and				
		ould be in the lowest position				
		towards the ground. The				
		ON confirmed that R36's bed				
	should always be at this height (approximately 16					
	inches off the ground) as this would be the lowest position for R36's bed. DON stated that R36					
	•	higher than 16 inches. DON				
	•	not confirm whether R36 was				
		ose of keeping his bed				
	being in the lowest po	osition and that R36's				
		the bed higher was not				
	documented in his ca	re plan.				
	3) During an observa	ation and concurrent				
	, -	2 at 02:20 PM, R17 had a				
	lighter stored in the b	edside bottom drawer. R17				
		was stored there after the				
	•	and that he was not aware				
		en handed over to the				
	nursing staff and stor	ed in the medication cart.				
	During staff interview	on 08/03/22 at 02:30 PM,				
	•	dged that the smoking				
	material (lighter) shou	uld have been collected from				
	R17 and stored in the	e medication cart.				
	Review of facility poli	cy on Smoking revealed the				
		atements: Purpose, to				
	· · ·	sive and explicit policy				
	• • •	eters of resident smoking to				
		dents and remain with				
		To stay in compliance with				
	• • • • • • • • • • • • • • • • • • • •	Accidents and Supervision				
		5(B) Self-determination and CFR 483.15(g) (1)(F250)				
		and emotional needs of				
		2 CFR 483.15(d)(F245) to				

Hawaii Dept. of Health. Office of Health Care	Accurance

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY IPLETED
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NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
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PU UWAI		WAIANA	AE, HI 96792			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
4 136	Continued From page	e 10	4 136			
	for how she/he spend outside the facility, 48 and takes into accour residents/guest that s this policy & procedur be required to return matches / cigarettes)	ividuals ' needs and choices Is time, both inside and 33.90(h)(5) smoking safety nt nonsmoking residents. All smoke3. Will adhere to re 6. Resident/guest will smoking material (lighter / to Charge Nurse/or ing from smoking area.				
4 149	11-94.1-39(b) Nursing (b) Nursing services limited to the following	shall include but are not	4 149			9/16/22
	each resident and the implementation of days of admission. T shall be developed in physician's admission initial orders. A nursi integrated with an developed by an inter	of a plan of care within five the nursing plan of care conjunction with the n physical examination and ng plan of care shall be overall plan of care rdisciplinary team no later t day after, or simultaneously,				
	summaries of the res	ing observations and ident's status recorded, as to changes in the resident's than quarterly; and				
		aluation and monitoring of sure quality resident care				
	This Statute is not m	et as evidenced by:				

# Hawaii Dept. of Health, Office of Health Care Assurance

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		125046	B. WING		08/	10/2022
			DDRESS, CITY, ST	ATE, ZIP CODE		
PU'UWAI '	Ο ΜΑΚΑΗΑ	WAIANA	E, HI 96792			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
4 149	Continued From page	e 11	4 149			
	failed to develop a baincluded the minimum necessary to safely of Resident (R)156 sam Findings include: On 08/03/22 at 2:16 F review of R156's Elect R156 was admitted to diagnosis that include congestive heart failut chronic obstructive pr Review of the Physic R156 was ordered Fu and may cause dehysi imbalance) 40 milligra 07/22/22. Review of (completed on 07/23/ management of the of the resident would not electrolyte imbalance On 08/03/22 at 3:12 F record review and int Nursing (DON). DON (furosemide) was not baseline care plan an the "how easy it is for	h healthcare information are for one resident pled. PM, conducted a record ctronic Health Record (EHR). to the facility on 07/22/22 with e cardiomyopathy, re, hypertension, and ulmonary disease (COPD). ian Orders documented urosemide (strong diuretic dration and electrolyte ams (MG) once a day on R156's baseline care plan 22) did not include rdered medication to ensure to experience dehydration or PM, conducted a concurrent erview with the Director of a confirmed the medication		<ol> <li>Resident # 156 has been disk MDS Coordinator, Staff Develop Unit managers were inserviced to base line care plans and medica the Director of Nursing. Inservice ongoing as needed.</li> <li>Newly admitted residents hav potential to be affected by this a practice.</li> <li>Licensed nurses were inservi Staff Developer / DON/designee comprehensive base line care p medications. Inservices will be of needed.</li> <li>To ensure compliance, MDS Coordinator / Unit managers will baseline care plans through recover weekly for a minimum of 12 wee compliance is achieved. The rest these audits will be brought to th Quality Assurance and Performa meeting for a minimum of three until compliance is achieved.</li> </ol>	er and regarding titions by es will be ve the lleged aced by the regarding lans and ingoing as audit ord review ks or until ults of he monthly ance	
4 175		ciplinary care process of care shall be reviewed	4 175			9/16/22

Office of Health Care Assurance STATE FORM

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NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           84-390 JADE STREET WAIANAE, HI 96792         84-390 JADE STREET WAIANAE, HI 96792           (PA) ID PRETIX TAG         SUMMARY STATEMENT OF DEFICIENCIES REGULTORY OR LSC IDENTFYING INFORMATION)         ID PRETIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         IC           4 175         Continued From page 12 and as necessitated by changes in the resident's condition.         4 175         I. Resident #30 bowel regimen was reviewed and protocol implemented as needed. Unit managers were inserviced regarding following the bowel protocol to prevent possible constipation by the Director of Nursing. Inservices will be ongoing as needed.           Findings include:         Cross reference to F760- Medication Errors On 08/03/22 at 10:05 AM, conducted a record review of R30's Electronic Health Record (EHR), Review of the R30's Medication Administration Record (intervention) to ensure bowel movement (BM) at least every 2-3 days, use laxatives as ordered.         3. Licensed nurse were inserviced by the Staff Developer / DON/designee regarding following the bowel protocol to on the results of these audits will be conging as needed.           Review of the R30's Medication Administration Record (MAR) documented the resident has routinely scheduled medications and three (3) as needed (FRN) medications on tor constipation. The resident's PRN medications are: -Milk of Magnesia (MOM) suspension 400 mg/5         A. To ensure compliance is achieved.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	,
Beyond the stress service of the service of th			125046	B. WING		08/10/202	22
WUMANE MAKAHA         WAIANAE, HI 98792           (M) D FRETIX TAG         Isummary statement of DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D FRETIX TAG         D (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D (EACH DEFICIENCY)         D (EA	NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
WAIANE, HI 95792           WAIANE, HI 95792         PROVIDER'S PLAN OF CORRECTION (EACH OPERCENCY AND SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PRETX TAG         PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APROPRIATE DEFICIENCY)           4 175         Continued From page 12 and as necessitated by changes in the resident's condition.         4 175           This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive person-centered care plan was implemented for one resident Resident (R)30 sampled. As a result of this deficiency, the resident is at risk for potential harm due to constipation.         1. Resident #30 bowel regimen was reviewed and protocol implemented as needed. Unit managers were inserviced regarding following the bowel protocol to prevent possible constipation by the Director of Nursing. Inservices will be ongoing as needed.           Findings include:         Cross reference to F760- Medication Errors On 08/03/22 at 10:05 AM, conducted a record review of R30's Electronic Health Record (EHR). Review of the resident's care plan documented a care plan for pressure ulcers related to incontinence of bowels and bladder with an approach (intervention) to ensure bowel movement (BM) at least every 2-3 days, use laxatives as ordered.         3. Licensed nurses were inserviced suil be ongoing as needed.           Review of the R30's Medication Administration Record (MAR) documented the resident has routinely scheduled medications of tor constipation. The results of these audits will be brought to the monthy Quality Assurance and Performance meneting for a minimum of theree months or until compliance is a chieved.		~	84-390 JA	DE STREET			
Differing TAG         (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDDITIFYING INFORMATION)         PREFIX TAG         CEACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APROPRIATE DEFICIENCY)         Continued From page 12           4 175         Continued From page 12 and as necessitated by changes in the resident's condition.         4 175         1. Resident #30 bowel regimen was reviewed and protocol implemented as needed. Unit managers were inserviced regarding following the bowel protocol to prevent possible constipation.         1. Resident #30 bowel regimen was reviewed and protocol implemented as needed. Unit managers were inserviced regarding following the bowel protocol to prevent possible constipation by the Director of Nursing. Inservices will be ongoing as needed.         2. Residents on the bowel protocol have the potential to be affected by this alleged practice.           On 08/03/22 at 10:05 AM, conducted a record review of R30's Electronic Health Record (EHR). Review of the resident's care plan documented a care plan for pressure ulcers related to incontinence of bowels and bladder with an approach (Intervention) to ensure bowel movement (BM) at least every 2-3 days, use laxatives as ordered.         1. Teesuitent managers will audit residents medication administration Record (MRR) documented the resident has routinely scheduled medications and three (3) as needed (PRN) medications are: -Milk of Magnesia (MOM) suspension 400 mg/5	U'UWAI '	O MAKAHA	WAIANAE	E, HI 96792			
<ul> <li>and as necessitated by changes in the resident's condition.</li> <li>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive person-centered care plan was implemented for one resident Resident (R)30 sampled. As a result of this deficiency, the resident is at risk for potential harm due to constipation.</li> <li>Findings include:</li> <li>Cross reference to F760- Medication Errors</li> <li>On 08/03/22 at 10.05 AM, conducted a record review of R30's Electronic Health Record (EHR), Review of the resident's care plan documented to care plan for pressure ulcers related to incontinence of bowels and bladder with an approach (intervention) to ensure bowel movement (BM) at least every 2-3 days, use laxatives as ordered.</li> <li>Review of the R30's Medication Administration Record (MAR) documented the resident has routinely scheduled medications and three (3) as needed (PRN) medications to for constipation. The resident's PRN medications are:</li> <li>-Milk of Magnesia (MOM) suspension 400 mg/5</li> </ul>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE CON	(X5) MPLET DATE
condition.This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive person-centered care plan was implemented for one resident Resident (R)30 sampled. As a result of this deficiency, the resident is at risk for potential harm due to constipation.1. Resident #30 bowel regimen was reviewed and protocol implemented as needed. Unit managers were inserviced regarding following the bowel protocol to prevent possible constipation by the Director of Nursing. Inservices will be ongoing as needed.Findings include: Cross reference to F760- Medication Errors2. Residents on the bowel protocol have the potential to be affected by this alleged practice.On 08/03/22 at 10:05 AM, conducted a record review of R30's Electronic Health Record (EHR). Review of the resident's care plan documented a care plan for pressure lucers related to incontinence of bowels and bladder with an approach (intervention) to ensure bowel movement (BM) at least every 2-3 days, use laxatives as ordered.3. Licensed nurses were inserviced by the Staff Developer / DON/designee regarding following the bowel protocol to aid in preventing constipation. Inservices will be ongoing as needed.Review of the R30's Medication Administration Record (MAR) documented the resident has routinely scheduled medications and three (3) as needed (PRN) medications to for constipation. The resident's PRN medications are: -Milk of Magnesia (MOM) suspension 400 mg/5	4 175	Continued From page	e 12	4 175			
Based on interview and record review, the facility failed to ensure comprehensive person-centered care plan was implemented for one resident Review of the R30's Medication Administration Review of the R30's Medication s of or constipation.1. Resident #30 bowel regimen was review of the R30's Medication ErrorsNetwork (MAR) documented the resident has routinely scheduled medications and three (3) as needed (PRN) medications to for constipation. The resident's PRN medications are:1. Resident #30 bowel regimen was review of the Magnesia (MOM) suspension 400 mg/5Mik of Magnesia (MOM) suspension 400 mg/51. Resident #30 bowel regimen was review of the Magnesia (MOM) suspension 400 mg/5			d by changes in the resident's				
ml; 30 ml, if no BM in 2 days         -Bisacodyl 10 mg suppository, if no BM in 3 days         -Enema 19-7 grams/118 ml, if no BM in 4 days         Review of R30's Vital Report and June/July MAR         documented R30's BM as:         06/02/22 at 10:19 AM- large BM		Based on interview a failed to ensure comp care plan was implem Resident (R)30 samp deficiency, the reside harm due to constipa Findings include: Cross reference to F7 On 08/03/22 at 10:05 review of R30's Elect Review of the resider care plan for pressure incontinence of bowe approach (interventio movement (BM) at le laxatives as ordered. Review of the R30's I Record (MAR) docum routinely scheduled n needed (PRN) medic The resident's PRN n -Milk of Magnesia (M ml; 30 ml, if no BM in -Bisacodyl 10 mg sup -Enema 19-7 grams/ <sup>2</sup> Review of R30's Vital documented R30's B	nd record review, the facility prehensive person-centered hented for one resident bled. As a result of this int is at risk for potential tion. 760- Medication Errors 760- Medication E		<ul> <li>reviewed and protocol implemented needed. Unit managers were inservi- regarding following the bowel protocol prevent possible constipation by the Director of Nursing. Inservices will be ongoing as needed.</li> <li>2. Residents on the bowel protocol I the potential to be affected by this a practice.</li> <li>3. Licensed nurses were inserviced Staff Developer / DON/designee reg following the bowel protocol to aid in preventing constipation. Inservices of ongoing as needed.</li> <li>4. To ensure compliance, unit mana will audit residents medication administration record, bowel records medical record weekly for a minimum 12 weeks or until compliance is ach The results of these audits will be but to the monthly Quality Assurance ar Performance meeting for a minimum three months or until compliance is</li> </ul>	as iced col to re have lleged by the garding n will be gers s and m of ieved. rought	

Office of Health Care Assurance STATE FORM

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Hawaii Dept.	of Health.	Office of Healt	h Care Assurance

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		125046	B. WING		08	/10/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	, ZIP CODE		
		84-390 J	ADE STREET			
PU'UWAI	Ο ΜΑΚΑΗΑ	WAIANAI	E, HI 96792			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
4 175	Continued From page	e 13	4 175			
	06/03/22- no BM					
	06/04/22- no BM					
		small BM. R30 should have				
	received MOM 30 mg					
	06/20/22 at 9:32 PM-	medium BM				
	06/21/22- no BM					
	06/22/22- no BM					
		0 should have received				
	MOM 30 mg but did r					
		R30 should have received				
	Bisacodyl 10 mg sup	pository but did not.				
	07/02/22 at 1:05 PM-	large BM				
	07/03/22- no BM					
	07/04/22- no BM					
		0 should have received				
	MOM 30 mg but did r	ot. 0 should have received				
	Bisacodyl 10 mg sup					
	07/07/22 at 01:59 AM					
	07/07/22 at 06:09 AM					
	07/08/22- no BM					
	07/09/22- no BM					
	07/10/22- no BM. R30	0 should have received				
	MOM 30 mg but did r					
		) should have received				
	Bisacodyl 10 mg sup					
		0 should have received an				
	enema but did not.					
	07/13/22- no BM. R30					
	Bisacodyl 10 mg supp 07/14/22 at 03:01 AM					
	07/16/22 at 8:12 PM-					
	07/17/22- no BM					
	07/18/22- no BM					
		0 should have received				
		administered Bisacodyl 10				
	mg suppository at 10					
	07/20/22- large BM					

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If continuation sheet 14 of 22

Hawaii Dept. of Health. Office	of Health Care Assurance
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	ept. of Health, Office of OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
125046		B. WING		08/10/2022	
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE	
		WAIANA	E, HI 96792		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	
4 175	07/21/22- no BM 07/22/22- no BM 07/23/22- no BM. R3 MOM 30 mg but was mg suppository at 11 07/24/22 at 03:14 AM On 08/04/22 at 3:30 record review of R30 the Director of Nursir is always incontinent ability to communicat DON confirmed R30	0 should have received administered Bisacodyl 10 :09 PM. I- large BM PM, conducted a concurrent 's EHR and interview with ng (DON). DON stated R30 of bowels and lacks the te bowel/constipation needs. was not administered PRN ed and indicated in the	4 175		
4 192	<ul> <li>11-94.1-46(i) Pharma</li> <li>(i) Appropriately lice be responsible for the administration, windividual dose from by a pharmacist included), verifying the physician's orders, the proper resident, a time, route, and dos signing the record. Ophysician, or other licensed professional responsibility pursual</li> </ul>	ensed and trained staff shall e entire act of medication which entails removing an a container properly labeled or manufacturer (unit dose ne dosage with the giving the specified dose to and promptly recording the se given to the resident, and Only a licensed nurse, her individual to whom the I has delegated the	4 192		9/16/22
		net as evidenced by: nd record review, the facility ications were administered		<ol> <li>Resident # 156 has been discharge Unit managers were inserviced regardi</li> </ol>	

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# Hawaii Dept. of Health, Office of Health Care Assurance

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED
	125046 B. WING			08/	10/2022	
NAME OF PF	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
		84-390 J	ADE STREET			
PU'UWAI '	О МАКАНА	WAIANA	E, HI 96792			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
4 192	Continued From page	e 15	4 192			
	as ordered for one re	sident Resident (R)156		following the bowel protocol to pr	event	
		of this deficiency, the		possible constipation by the Direc		
		ed constipation and could		Nursing. Inservices will be ongoir		
	potentially experience	e harm if not addresses.		needed.	•	
				2. Residents on the bowel protoc		
	Findings include:			the potential to be affected by this practice.	s alleged	
	1) On 08/03/22 at 11:37 PM, conducted a record			3. Licensed nurses were inservice		
		ctronic Health Record (EHR).		Staff Developer / DON/designee		
		vsician Orders documented		following the bowel protocol to aid		
		gnesium (MOM) if no bowel		preventing constipation. Inservice	es will be	
		days, Dulcolax suppository		ongoing as needed. 4. To ensure compliance, unit ma	pagara	
		no BM by MOM in the if no result from Dulcolax		will audit residents medication	anagers	
		orning, notify the doctor if no		administration record, bowel reco	rds and	
	BM from enema. Rev			medical record weekly for a minir		
	(initiated on 07/27/22			12 weeks or until compliance is a		
	management of the re			The results of these audits will be		
		tions as needed for BM.		to the monthly Quality Assurance	and	
	Review of R156's Vita	al Report (staff documented		Performance meeting for a minim	um of	
	resident's BM) docum	nented R156 had a bowel		three months or until compliance	is	
		22 then the next BM was on		achieved.		
	07/31/22 (4 days).					
	On 08/4/22 at 3:12 Pl	M, conducted a concurrent				
		56's EHR) and interview with				
		g (DON). After reviewing				
	R156's Physician Orc					
		d, and Vitals Report (BM),				
		should have received MOM				
	on 07/30/22 but the n					
	administered as orde	rea.				
	Cross Reference to F	656- Implementation of				
	Care Plan					
	2) On 08/03/22 at 10:	05 AM, conducted a record				
	-	ronic Health Record (EHR).				
		nt's care plan documented a				
	care plan for pressure		1			1

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STATEMENT	OF DEFICIENCIES OF CORRECTION	f Health Care Assurance (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		COMI	E SURVEY PLETED
		125046			08	/10/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	О МАКАНА	84-390 .	JADE STREET			
100MA		WAIANA	AE, HI 96792			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
4 192	Continued From page	e 16	4 192			
	approach (interventio	ls and bladder with an n) to ensure bowel ast every 2-3 days, use				
Record (MAR) of routinely schedu needed (PRN) r	Record (MAR) docum routinely scheduled n	Medication Administration nented the resident has nedications and three (3) as ations to for constipation. nedications are:				
	ml; 30 ml, if no BM in -Bisacodyl 10 mg sup	OM) suspension 400 mg/5 2 days opository, if no BM in 3 days 118 ml, if no BM in 4 days				
	Review of R30's Vital documented R30's B	Report and June/July MAR M as:				
	06/02/22 at 10:19 AM 06/03/22- no BM 06/04/22- no BM 06/05/22 at 5:49 PM- received MOM 30 mg	small BM. R30 should have				
	MOM 30 mg but did r	0 should have received not. R30 should have received				
	MOM 30 mg but did r	0 should have received not. 0 should have received				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		125046	B. WING		08	/10/2022
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	_	84-390	JADE STREET			
U'UWAI '	Ο ΜΑΚΑΗΑ	WAIAN	IAE, HI 96792			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
4 192	07/07/22 at 01:59 AM 07/07/22 at 06:09 AM 07/08/22- no BM 07/09/22- no BM 07/10/22- no BM. R30 MOM 30 mg but did r 07/11/22- no BM. R30 Bisacodyl 10 mg supp 07/12/22- no BM. R30 Bisacodyl 10 mg supp 07/13/22- no BM. R30 07/13/22- no BM. R30 07/14/22 at 03:01 AM 07/16/22 at 8:12 PM- 07/17/22- no BM 07/18/22- no BM 07/19/22- no BM 07/19/22- no BM. R30 MOM 30 mg but was mg suppository at 10: 07/20/22- large BM 07/21/22- no BM 07/22/22- no BM 07/23/22- no BM. R30 MOM 30 mg but was mg suppository at 11: 07/24/22 at 03:14 AM On 08/04/22 at 3:30 F record review of R30 the Director of Nursin is always incontinent ability to communicate DON confirmed R30 medication as ordered	<ul> <li>medium BM</li> <li>small BM</li> <li>should have received tot.</li> <li>should have received pository but did not.</li> <li>should have received an</li> <li>was administered pository at 11:01 PM.</li> <li>medium BM large BM</li> <li>should have received administered Bisacodyl 10 52 PM.</li> <li>should have received administered Bisacodyl 10 52 PM.</li> <li>should have received administered Bisacodyl 10 09 PM.</li> <li>large BM</li> <li>PM, conducted a concurrent s EHR and interview with g (DON). DON stated R30 of bowels and lacks the e bowel/constipation needs. was not administered PRN d and indicated in the</li> </ul>	4 192			
4 000	constipation. 11-94.1-53(a) Infectio		4 203			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		125046	B. WING		08/10/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	<b></b>	84-390 J	ADE STREET			
PU'UWAI	О МАКАНА	WAIANA	E, HI 96792			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	
4 203	Continued From page	e 18	4 203			
	(a) There shall be a	ppropriate policies and				
		nd implemented for the				
		ntrol of infectious diseases				
	that shall be in comp	liance with all applicable				
	laws of the State a	nd rules of the department				
	relating to infectious	diseases and infectious				
	waste.					
	This Statute is not m	et as evidenced by:				
	Based on observations, interviews, and record			1. The staff member was inserviced b	v	
	review, the facility failed to 1) ensure infection			the DON regarding appropriate infecti	-	
	control practices were implemented to help			control practices when entering and		
	prevent the development and transmission of			leaving a Yellow Zone. R # 156 has be	een	
	communicable diseases and infections, 2) label			discharged. Signage for zones was		
	Resident (R) 206's tube feeding formula, saline			reviewed and updated as needed.		
	-	eeding syringe appropriately.		Resident #206□s tube feeding bag, tu	-	
		iciency, residents are at a		and syringe were replaced with labele		
		ting or developing and		supplies. Licensed nurse involved was	S	
	infection that could affect their health and potential harm the residents.			inserviced regarding labeling and changing tube feeding supplies by Sta	off	
				Developer. Inservices will be ongoing		
	Findings include:			needed.		
	1) On 08/04/22 at 08	:45 AM, observed Kitchen		2. Facility residents have the potentia be affected by this alleged practice.		
		oom in the Yellow Zone. KS1		3. Facility staff were re-inserviced		
		aring a face shield, surgical		regarding infection control practices a	and	
		and a backward baseball		procedures, signage precautions and		
		room with a face shield and		labeling tube feeding supplies by the		
		1 walked out of the yellow		Developer / DON/designee. Inservice	s will	
		nen turned around and went		be ongoing as needed.		
		m to wipe the face shield.		4. DON / Unit managers /designee w		
	exiting the Yellow Zor	ew surgical mask before		monitor compliance through observation on daily rounds weekly for a minimum		
		ю.		12 weeks or until compliance is achieved		
	On 08/04/22 at 09:05	AM, conducted an interview		The results of these audits will be brown		
		t Infection Preventionist until		to the monthly Quality Assurance and	-	
		DON explained Resident		Performance meeting for a minimum of		
		mitted, unvaccinated, and in		three months or until compliance is		
		er quarantine. Inquired what		achieved.		

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Hawaii Dept.	of Health.	Office of Health	Care Assurance

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		125046	B. WING		08	/10/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		84-390 J	ADE STREET			
PU'UWAI '	O MAKAHA		E, HI 96792			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
4 203	Continued From page	e 19	4 203			
	protoctivo oquipmont	(PPE) staff should use				
		in the Yellow Zone. Shared				
		personal usage in the				
		DON. The DON confirmed				
		cleaned the face shield				
		ting the room and prior to				
	•	•				
	-	ne area and should have to the resident's room.				
	WOITI AIT IN95 THASK III	to the resident's room.				
	Inquired with the DOI	N regarding no signs posted				
	outside the Yellow Zone rooms as to how staff					
	knew what type of PPEs they were supposed to					
	don before going into a room on the Yellow Zone					
		s posted informing/reminding				
	-	there were no signs posted				
		ses a color coded system to				
	identify the type of PI					
	• •	that was conducted on				
		with Registered Nurse				
		's knowledge of the type of				
		worn in the Yellow Zone.				
		as vaccinated a surgical				
		in the room, but if staff was				
		id to wear a N95 mask. The				
		's was incorrect and N95				
		by all staff in the rooms				
	located in the Yellow					
	2) On 08/02/22 at 10:	:04 AM, R206's tube feeding				
		ush bag, and tube feeding				
	flush syringe was obs	served hanging on an				
	intravenous pole in R	206's room. The tube				
	feeding formula bag l	nad formula in it. The tube				
		was not labeled with the				
	resident's name, date	e, name of the formula, the				
	amount to be given, r	nor the frequency of				
	feedings. The tube feedings.	eeding formula bag tubing				
	-	e saline bag and its tubing				
		I. The tube feeding flush				
		in a plastic bag and was				

Hawaii D	ept. of Healt	h Office of I	Health Care	Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (7	(X3) DATE SURVEY COMPLETED 08/10/2022	
		125046	B. WING			
AME OF PF	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STA	ATE, ZIP CODE		
	<b>•</b> • • • • • • • • • • • • • • • • • •	84-390	JADE STREET			
UUWAI	Ο ΜΑΚΑΗΑ	WAIANA	AE, HI 96792			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
4 203	Continued From page	e 20	4 203			
	also not labeled.					
		AM, a concurrent interview				
		done with Resident Care M observed R206's tube				
	÷ , ,	saline bag, and tube feeding				
		firmed that there were no				
		RCM stated that the tube				
	• •	saline bag, and tube feeding ed with the resident's name,				
		stated that a new tube				
		s hanged every night and				
	should have been lab					
		PM, a record review of				
		der Report" indicated that				
		r "Fibersource HN liquid; l; amt: 375 ml; feeding tube				
	•	9:00, 13:00, 17:00, 21:00."				
	On 08/04/22 at 09:00	AM, a review of the facility's				
		Feeding: Intermittent" dated				
	12/15/21 was done.					
		el all bags, tubing, and esident's name and the date				
		ere opened for use. Label				
		e of the formula, the amount				
	to be given, and frequ	ency of the feedings."				
	11-94.1-64(a) Engine	ering and maintenance	4 243		9/16/22	
	(a) The facility shall	maintain all essential				
	mechanical, electrical					
		e operating condition.				
	This Statute is not m	et as evidenced by:				
	Based on observatior	ns and interviews, the facility		1. Resident # 26 s oxygen concentrate	or	
		e environment for one		was replaced. Director of Nursing		
	resident Resident (R)	26 sampled. As a result of		inserviced licensed nurse on duty		

STATE FORM

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#### Hawaii Dept. of Health, Office of Health Care Assurance

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	125046	B. WING		08/	/10/2022	
ROVIDER OR SUPPLIER			ATE, ZIP CODE			
О МАКАНА						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE	
Continued From page	21	4 243				
this deficiency, there is residents that use oxy concentrators. Findings include: Conducted an observ 12:31 PM. The reside was connected to an of the oxygen concen- humidifier canister was concentrator by a pur Additionally, the oxyg plugged into a power resident's bed power On 08/05/22 at 10:50 concurrent interview a oxygen concentrator v (DON). The DON cor concentrator should h into the red (emergen a power strip. The DO canister was fastened bungee because the of the machine was brok that the bungee cord canister from slipping DON acknowledged t	s the potential for harm for gen machines with ation of R26 on 08/02/22 at ent had a tracheostomy and oxygen machine. Inspection trator revealed the us fastened to the ple bungee cord. en concentrator was strip along with the cord. AM, conducted a and observations of R26's with the Director of Nursing nfirmed the oxygen ave been plugged directly cy power) outlet and not into DN stated that the humidifier I onto the concentrator by a manufacturer's holder for ten. Pointed out to the DON alone could not prevent the out from the bottom. The he canister could slip out		<ul> <li>function and usage. Inservice ongoing as needed.</li> <li>2. Residents using oxygen of have the potential to be affed alleged practice.</li> <li>3. Licensed nurse and CNA inserviced regarding approproconcentrator function and us Staff Developer/ designee. In be ongoing as needed.</li> <li>4. DON / Unit managers /demonitor compliance through on daily rounds weekly for a 12 weeks or until compliance The results of these audits w to the monthly Quality Assurples.</li> </ul>	es will be concentrators cted by this s were riate oxygen age by the nservices will observations minimum of e is achieved. rill be brought ance and ninimum of		
	(EACH DEFICIENCY REGULATORY OR L Continued From page this deficiency, there is residents that use oxy concentrators. Findings include: Conducted an observent 12:31 PM. The reside was connected to an of of the oxygen concern humidifier canister was concentrator by a purp Additionally, the oxyge plugged into a power resident's bed power concurrent interview at oxygen concentrator v (DON). The DON cor concurrent interview at oxygen concentrator v (DON). The DON cor concentrator should h into the red (emergen a power strip. The DO canister was fastened bungee because the r the machine was brok that the bungee cord at canister from slipping DON acknowledged ti	OF CORRECTION       IDENTIFICATION NUMBER:         125046       125046         ROVIDER OR SUPPLIER       STREET A         O MAKAHA       84-390 J         WAIANA       WAIANA         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       VIOLATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 21       this deficiency, there is the potential for harm for residents that use oxygen machines with concentrators.	DF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         125046       B. WING	PF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING:         125046       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         0 MAKAHA       84-390 JADE STREET         0 MAKAHA       WAIANAE, HI 96792         0 Continued From page 21       ID         1 this deficiency, there is the potential for harm for residents that use oxygen machines with concentrators.       regarding appropriate oxyge function and usage. Inservice organing as needed.         2. Residents using oxygen of the oxygen concentrator service from the source of the concentrator service or enganding appropriate oxyge indicating appropriate oxyge indicating appropriate oxyge function and usage. Inservice organing as needed.         2. Residents using oxygen on the bunge cord.       A dditionally, the oxygen concentrator revealed the humidifier canister was fastened to the concentrator should have been plugged into a power strip along with the Director of Nursing (DON). The DON confirmed the oxygen concentrator was plugged into a power strip. The DON stated that the humidifier canister was fastened out to the concentrator by a purgle bunge cord.       4. DON / Unit managers /de monitor compliance through on daily rounds weekly for a na toxygen concentrator was plugged directly into the results of these audits w to the monthly Quality Assure Performance meeting for a na toxygen concentrator to prove of Nursing (DON). The DON confirmed the oxygen concentrator by a purgle bunge cord.         DON acknowledged the canister could slip out       The output conting the oxygen concentrator function and us to the monthly Quality Assure Performance meeting fo	op CORRECTION       IDENTIFICATION NUMBER:       A BUILDING:       COMP         125046       B. WING       08.         OWDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY WILL BE PRECEDED DE PY PLLL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREVIDERS PLAN OF CORRECTION (REACH CORRECTION ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY WILL BE PRECEDED BUT PULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREPIX TAG       PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)         Continued From page 21       4 243       regarding appropriate oxygen concentrator function and usage. Inservices will be ongoing as needed.         Conducted an observation of R26 on 08/02/22 at 12:31 PM. The resident had a tracheostomy and was connected to an oxygen machine. Inspection of the oxygen concentrator revealed the humidifier canister was fastened to the concentrator by a purple bungee cord.       3. Licensed nurse and CNAs were inserviced regarding appropriate oxygen. Concentrator by a purple bungee cord.         ON 08/05/22 at 10:50 AM, conducted a concurrent interview and observations of R26's oxygen concentrator with the Director of Nursing (DON). The DON confirmed the oxygen concentrator should have been plugged directly into the red (emergency power) outlet and not into a power strip. The DON stated that the humidifier canister was fastened onto the concentrator by a bungee because the manufacturer's holder for the machine was broken. Dointed out to the DON that the bungee cord alone could not prevent the canister from slipping out from the bottom. The DON acknowledged th	