STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125056	A. BUILDING _____ B. WING _____	R 07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE MAKUA HEALTH SERVICES	1540 LOWER MAIN STREET WAILUKU, HI 96793

(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 000	INITIAL COMMENTS An onsite revisit was conducted by the Office of Health Care Assurance on July 26 to July 27, 2022. The facility was found not to be in substantial complaince with 42 CFR 483 Subpart B. Two facility reported incidences (FRI), #9592 and #9668, from the Aspen Complaints/Incidents Tracking System (ACTS) were also investigated and found to be substantiated. On 07/26/22 at 4:18 PM, the Administrator and Director of Nursing (DON) were notified that the failure to protect their female residents from Resident (R)52's on-going non-consensual sexual abuse constituted an immediate jeopardy (IJ) at F600 Free from Abuse and Neglect. The IJ at F600 also involved Substandard Quality of Care at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation. The IJ was determined to first exist on 06/15/22, when R52 exposed his gentalia to R47. The facility provided an acceptable plan for removal of the IJ on 07/27/22 at 08:29 AM. The survey team validated that the IJ was removed on 07/27/22 at 10:30 AM following the facility's implementation of the plan for removal of the IJ.	F 000		
{F 600} SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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	{F 600}		8/22/22

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

Electronically Signed | 08/21/2022

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 600}	Continued From page 1 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to protect four female residents (R), R47, R54, R41, R66 from R52's escalating non-consensual sexual abuse. This deficient practice constitutes as an immediate jeopardy (IJ) situation as there is a potential for one or many female resident(s), who are all vulnerable, to suffer serious injury or harm, including those psychosocial in nature, from R52's ongoing sexual abuse. On 07/26/22 at 4:18 PM, an immediate jeopardy (IJ) was called and the Administrator and DON were notified. The facility failed to protect their female residents from R52's sexual abuse by not providing constant one to one monitoring of R52 which necessitates that R52 be in the line of sight of staff at all times. The IJ template was provided to the Administrator at this time and the Administrator signed the document to confirm receipt of the IJ template. On 07/27/22 at 08:16 AM, the facility's IJ removal plan was received by the Administrator and the Director of Nursing (DON). The removal plan included that the facility's female residents will be protected from R52's sexual abuse by ensuring that continuous one to one monitoring of R52 was	{F 600}	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Resident 52 is no longer at the facility. Resident was discharged 8/1/2022. He continued one on one staff to Resident ratio until discharge. Residents 34,41,47,54 and 66 have been assessed by Social Service Director and continue to be followed as needed. Staff involved in incident were inserviced. Facility assessment was updated to reflect the denial of admission to individuals with a history of sexual behaviors. Social services will ensure residents exhibiting any sexual behaviors will be referred immediately upon detection through observations, reports and record review to psych services. Facility Residents have the potential to be affected by the alleged practice.	

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{F 600}	Continued From page 2 instituted with the start date of 07/26/22. A behavior report will be provided by the staff performing the one to one monitoring of R52 to the charge nurse at the end of each shift. The physician will be contacted for further evaluation and R52's family will be contacted for a care plan meeting where additional interventions will be explored with R52's family, physician, and the facility. All staff will be educated on the facility's one to one monitoring procedure, their resident abuse reporting responsibilities, and their responsibility to ensure the safety of all of their residents. On 07/27/22 at 08:29 AM, the state agency (SA) accepted the facility's IJ removal plan. On 07/27/22 at 10:30 AM, SA confirmed the implementation of the IJ removal plan and verified that the facility's IJ had been removed. Findings include: 1) On 07/26/22 at 07:00 AM, reviewed intake #9592 from the Aspen Complaints/Incidents Tracking System (ACTS). On 06/15/22 around 1:00PM, R47 saw R52 in the courtyard from a distance, stand up from his wheelchair, lowered his pants, and then pulled his pants up. R52 sat down in his wheelchair and propelled towards R47. R47 saw that R52's genitalia was visible. R47 yelled, stated for R52 to get away, and yelled for Certified Nursing Assistant (CNA)6 to help. CNA6 came out of a resident's room after providing care and saw R52's sitting in his wheelchair with his genitalia visible outside of his shorts. CNA6 assisted R52 with adjusting his clothing so that his genitalia was no longer visible and wheeled him away from R47. During the Administration's investigation of the incident, R47	{F 600}	Facility staff were inservices on one to one supervision policy by Staff Development Coordinator/Director of Nurses/Designee. Inservices will be ongoing as needed. Administrator/Director of Nurses/Designee will monitor through observation and medical record review weekly X12 weeks or until compliance is achieved. Administrator will take results to Quality Assurance Performance Improvement meetings monthly for 3 months or until compliance is achieved.	

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{F 600}	Continued From page 3	{F 600}		

stated that she felt R52's sexual misconduct was intentional. A second incident occurred between 7:00 PM to 7:30 PM, where staff observed R52 masturbating while standing by his wheelchair in the facility's hallway. No other residents were present outside in the hallway at the time. R52 was redirected back to his room where he could masturbate in private and re-educated that that behavior was not acceptable in public areas. One of the interventions to manage R52's behavior was to provide "1:1 (one staff to one resident monitoring) and continued monitoring."

On 07/26/22 at 3:00 PM, reviewed R52's "Q (every) 30 minutes Checks For 24 hours" flowsheet for 06/15/22. DON clarified that the flowsheet was for the documentation of the one staff dedicated to R52's care (one to one monitoring). There was a line drawn through the time and initial boxes from 07:00 AM to 1:30 PM.

On 07/26/22 at 3:54 PM, a concurrent interview and record review was done with the Administrator and DON. The DON stated that one dedicated staff was provided for R52 during the day shift, 06:30 AM to 3:00 PM and every 30 minute monitoring was done by the CNA during the evening and night shifts. During the concurrent record review of R52's "Q 30 minutes Checks For 24 hours" document for 06/15/22 with the DON and Administrator, it was confirmed that R52 was not monitored one to one by staff from 07:00 AM to 1:30 PM.

On 07/27/22 at 08:30 AM, reviewed the facility's "One to one" policy and procedure (P/P) with original effective date 05/10/21, it stated, " ...1.One-to-One supervision requires that a patient is never out of line of sight from the staff

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{F 600}	Continued From page 4 at all times. a) The patient is accompanied by the staff member at all times (including bathing, showering, shaving, and toileting)." 2) On 07/26/22 at 10:07 AM, R52's electronic health record (EHR) was reviewed. A progress note documented by licensed nurse (LN)10 on 07/24/22 at 10:13 PM, revealed that LN10 saw R52 place R54's hand on his exposed genitalia. R41, who was sitting close to R54, stated, " ...He pulled out his thing in front of me and I told him don't you do that to me." Two hours later, R52 wheeled past R66 and R66 stated to LN10 that R52 told R66 that "he wants to look between my legs." An hour after that incident, R52 needed assistance in the bathroom by signaling the bathroom call light. R52 needed assistance to pull up his pants and when the CNA helped him, he touched himself inappropriately. On 07/26/22 at 1:15 PM, received and reviewed the facility's incident report entered on 07/24/22 describing R52's alleged sexual abuse of R41, R54, and R66. The incident involving R52's sexual abuse of these female residents that was described in LN10's progress note on 07/24/22 at 10:13 PM, was documented on the report as having occurred at "16:00" or 4:00 PM. On 07/26/22 at 3:54 PM, a concurrent interview and record review was done with the Administrator and DON. The "Q (every) 30 Minutes Checks for 24 hours" on 07/24/22 was reviewed. Staff documentation of R52's one to one monitoring started at 10:30 PM. The Administrator and DON were asked why R52 was not on one to one monitoring with one staff after the initial sexual abuse of R54 at 4:00 PM and with continued sexual abuse allegations with a	{F 600}		

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{F 600}	Continued From page 5 few more female residents thereafter. The Administrator stated that the LN10 reported the witnessed sexual abuse of R54 to the charge nurse, but the charge nurse did not recall being told of the incident. Another sexual abuse allegation involved R47 and R52 occurred at 10:00 PM and the one to one monitoring of R52 was instituted at 10:30 PM. R52 was in the same hallway with R47 and R52 pointed to his genitalia while looking at R47. R47 yelled and staff intervened. The Administrator stated that he was not made aware initially of the earlier sexual abuse allegations at 4:00 PM. He further stated that he reported the sexual abuse occurrences to APS on 07/26/22, but not with the police department (PD). On 07/27/22 at 08:00 PM, the facility's "Comprehensive Abuse Policy and Prevention Program" policy and procedure last updated on 03/03/21, was reviewed. It stated under, "7) Reporting / Responding: ...Procedures: Staff are to report suspected violations to their supervisor immediately, who in turn will notify the Administrator. The Administrator or designee will report to the state survey agency and others (police, APS, OIG,AG, etc) will be notified as mandated by regulation and/as needed alleged abuse (this includes sexual assault) no later than 2 hrs. (hours) of the allegation, if events that cause the allegation abuse or result in serious bodily injury." Cross reference F609 Reporting of Alleged Violations	{F 600}		
{F 609} SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	{F 609}		8/22/22

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{F 609}	Continued From page 6 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to report Resident (R)52's alleged sexual abuse of R54, R41, R66, immediately to the supervisor and within the two hour timeframe to the state agency (SA) and police department (PD). This deficient practice can affect all the facility's female residents and fails to provide them necessary protections after they have suffered from R52's alleged sexual abuse. Finding includes:	{F 609}	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. The incidents of 7/24/2022 were reported	

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{F 609}	Continued From page 7 On 07/26/22 at 10:07 AM, R52's electronic health record (EHR) was reviewed. A progress note documented by nursing on 07/24/22 at 10:13 PM, revealed that licensed nurse (LN)10 saw R52 place R54's hand on his exposed genitalia. R41, who was sitting close to R54, stated, " ...He pulled out his thing in front of me and I told him don't you do that to me." Two hours later, R52 wheeled past R66 and R66 stated to LN10 that R52 told R66 that "he wants to look between my legs." An hour after that incident, R52 needed assistance in the bathroom by signaling the bathroom call light. R52 needed assistance to pull up his pants and when the CNA helped him, he touched himself inappropriately. On 07/26/22 at 1:15 PM, received and reviewed the facility's incident report entered on 07/24/22, describing R52's alleged sexual abuse of R41, R54, and R66. The incident involving R52's sexual abuse of these female residents that was described in LN10's progress note on 07/24/22 at 10:13 PM, was documented on the report as having occurred at "16:00" or 4:00 PM. On 07/26/22 at 3:54 PM, a concurrent interview and record review was done with the Administrator and DON. The "Q (every) 30 Minutes Checks for 24 hours" on 07/24/22 was reviewed. Staff documentation of R52's one to one monitoring started at 10:30 PM. The Administrator and DON were asked why R52 was not on one to one monitoring with one staff after the initial sexual abuse of R54 at 4:00 PM and with continued sexual abuse allegations with a couple of more female residents thereafter. The Administrator stated that the LN10 reported the witnessed sexual abuse of R54 to the charge	{F 609}	to Office of Health Care Assurance and Adult Protective Services on 7/25/2022. The Administrator, Director of Nurses and Social Service Director were inserviced by the Regional Nurse regarding reporting of incidents and timelines. Inservices will be ongoing and as needed. Facility Residents have the potential to be affected by the alleged practice. Facility staff were inservices regarding reporting abuse and neglect and timeliness by the Staff Development Coordinator/Designee. A check off list for reporting abuse allegations was implemented for guidance to staff. Inservices will be ongoing as needed. Administrator/Director of Nurses/Designee will monitor through observation and medical record review weekly X12 weeks or until compliance is achieved. Administrator will take results to Quality Assurance Performance Improvement meetings monthly for 3 months or until compliance is achieved.	

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{F 609}	Continued From page 8 nurse, but the charge nurse did not recall being told of the incident. Another sexual abuse allegation involved R47 and R52 occurred at 10:00 PM and the one to one monitoring of R52 was instituted after that at 10:30 PM. R52 was in the same hallway with R47 and R52 pointed to his genitalia while looking at R47. R47 yelled and staff intervened. The Administrator stated that he was not initially aware of the earlier sexual abuse allegations at 4:00 PM. He further stated that he reported the sexual abuse occurrences of 07/24/22 to APS on 07/26/22, but not with the police department (PD). On 07/27/22 at 08:00 PM, the facility's "Comprehensive Abuse Policy and Prevention Program" policy and procedure last updated on 03/03/21, was reviewed. It stated under, "7) Reporting / Responding: ...Procedures: Staff are to report suspected violations to their supervisor immediately, who in turn will notify the Administrator. The Administrator or designee will report to the state survey agency and others (police, APS, OIG,AG, etc) will be notified as mandated by regulation and/as needed alleged abuse (this includes sexual assault) no later than 2 hrs. (hours) of the allegation, if events that cause the allegation abuse or result in serious bodily injury."	{F 609}		
{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	{F 656}		8/22/22

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{F 656}	Continued From page 9 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive 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 observation, interviews, and record review, the facility failed to ensure a comprehensive person-centered care plan was	{F 656}	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission	

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{F 656}	Continued From page 10 developed for one resident (R), R38, out of three residents sampled. As a result of this deficiency, there is the potential for harm related to not maintaining the resident's highest practicable physical well-being. Findings include: Conducted a record review for R38 on 07/27/22 at 10:15 AM. Review of the physician orders documented an order for restorative nursing program, apply to wrist/ hand orthosis/ splint to right-hand during the day (08:00 AM) and remove 6 hours after (2:00 PM). The order was initiated on 04/15/21 and was last reviewed on 07/05/22 at 09:27 AM. Review of the resident's comprehensive care plan was not developed to address the resident's use or refusal of the right hand splint as ordered. An observation was made of R38 on 07/27/22 at 10:27 AM. The resident did not have a right wrist splint applied as ordered. Inquired with Registered Nurse (RN)22 about R38's right wrist splint. RN22 stated that R38 has not had the splint for a while. On 07/27/22 at 10:50 AM, conducted a record review and concurrent interview with the Director of Nursing (DON). The DON confirmed R38 did have an order to apply a right-handed splint from 08:00 AM to 2:00 PM and a comprehensive care plan was not developed to address the resident's use or refusal of the splint.	{F 656}	of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Resident 38 was re-evaluated by occupational therapy and is being treated as directed. Care plan was updated to reflect therapy and treatment. Director of Nursing inserviced nursing staff involved. Inservices will be ongoing as needed. Facility resident's care plans were reviewed and updated as needed. Facility Residents have the potential to be affected by the alleged practice. Licensed Nurses, Direct Care, and Interdisciplinary Team were inservices on care planning and updating care plans. Inservices will be ongoing as needed. Director of Nurses/Designee will monitor compliance through weekly medical record review X12 weeks or until compliance is achieved. Director of Nurses will take results to Quality Assurance Performance Improvement meetings monthly for 3 months or until compliance is achieved.	
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		8/22/22

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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 688	Continued From page 11 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure residents with limited range of motion (ROM) received appropriate treatment and services to increase ROM and/or prevent further decrease in ROM. As a result of this deficiency, there is the potential for harm and decreased quality of life for residents. Findings include: Upon entering the facility on 07/26/22, requested with the Administrator and Director of Nursing (DON) for all of the facility's documentation related to the Plan of Correction (POC) for the recertification survey that was conducted on 05/20/22. As part of the facility's POC, current residents would be reviewed to ensure the resident's restorative, positioning, and turning needs were addressed and the residents were receiving the appropriate services.	F 688	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Facility Residents were reassessed and screened for restorative/range of motion (ROM) and positioning needs. Residents were referred to therapy as needed. Director of Nursing (DON)/ Staff Development Coordinator (SDC)/ Designee inserviced licensed nursing staff regarding ROM, positioning, and restorative services. Inservices will be ongoing as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125056	A. BUILDING _____ B. WING _____	R 07/27/2022

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F 688	Continued From page 12 On 07/27/22 at 09:34 AM, conducted an interview with the DON regarding the documentation requested on 07/26/22. The DON confirmed the facility did not complete screening of current residents as indicated in the facility's plan of correction and cannot confirm that the ROM needs of current residents are receiving the appropriate ROM treatments and services.	F 688	Facility Residents have the potential to be affected by the alleged practice. SDC/ Designee inserviced licensed nursing staff and direct care staff regarding ROM, positioning and restorative services. Inservices will be ongoing as needed. DON/SDC/ Designee will monitor compliance through observations on rounds, reviewing positioning and turning by use of the 2 hour turning tool on rounds through the shift and medical record reviews X 12 weeks. DON will bring results to Quality Assurance Performance Improvement meetings monthly for 3 months or until compliance is achieved.	