STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(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 relicensure survey was conducted by the Office of Healthcare Assurance (OHCA) on 07/22/21. The facility was not in substantial compliance with Hawaii Administrative Rules, Title 11, Chapter 94.1. Survey dates: 07/19/21 to 07/22/21. Survey Census: 79 Sample Size: 18	4 000		
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 record reviews and interviews, the facility failed to develop effective and individualized care plans (CP) for two of 19 residents sampled (Resident (R) 80 and R24). Interventions were not developed to address problems identified for R80. Non-pharmacological interventions to address behaviors related to the use of psychotropic medication was not developed for R24. Findings include: 1) On 07/20/22 at 11:49 AM, a record review (RR) of R80's electronic health record (EHR) was done. R80 was a 77 year old resident admitted to	4 174	HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS) WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT #80 AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "DON, SW, MDS reviewed Resident #80□s care plan where problem identified, I refused care at times, yells or screams during care was initiated on 05/03/2022 and incomplete. Goal and interventions were NOT documented in the care plan. In	9/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(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
4 174	Continued From page 1 the facility on 04/18/22 for advanced dementia (a condition with the impaired ability to remember, think, or make decisions that interferes with daily activities), and family were unable to care for R80 at home due to increased care needs. R80's CP was reviewed. Problem identified, "I refused care at times, yells or screams during care," initiated on 05/13/22, had no goal or interventions outlined for this behavior. Problems for having come from a home environment, admitted to the facility with dementia, and needing isolation for COVID-19 precautions were also not identified on R80's CP. On 07/21/22 at 2:45 PM, a concurrent interview and RR were done with Unit Manager (UM)3 in her office. UM3 confirmed that no goal and interventions were identified for the problem, "I refused care at times, yells or screams during care." UM3 identified that behavior interventions are present on the "MONITORS" flowsheet that only the registered nurses have access to, but no other disciplines have access to this and therefore would not know how to effectively and individually care for R80's behaviors. UM3 stated that R80's problem with coming from a home environment and transitioning into a facility with dementia and being isolated for COVID-19 precautions should have been identified on the care plan and interventions developed to provide the optimal care for R80. On 07/22/22 at 08:00 AM, the facility's "Comprehensive Care Plan Guideline" was reviewed. It stated under "Procedure:...2. This comprehensive care plan will address resident goals, actual and potential problems, needs, strengths and individual preferences of the resident."	4 174	addition, we concur that problems were not identified such as resident with dementia, new/unfamiliar environment and needing isolation. IDT reviewed this incomplete care plan and citation, and concurred that care should have been completed to address resident□s problems/needs/behavior. UM3 reviewed 7/21, DON, SW, MDS coordinator/IDT reviewed on 08/10/22 HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "Residents admitted/readmitted and currently placed in isolation have been identified. Completed 08/08/22 "MDS and IDT will review care plans to ensure it is complete with resident□s problems/needs, goals, and interventions. Start 08/15/22 - Ongoing HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: "MDS and IDT will create a Care plan for all New Admissions/Readmissions, where resident will be placed on quarantine or isolation. This care plan will address	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(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
4 174	Continued From page 2 2) R24 was admitted to the facility on 10/06/21 with diagnoses of inadequate sleep hygiene and unspecified dementia without behavior disturbance. Record review of a psychiatry consult dated 05/12/22 documents reason for visit, "behavioral problems", and vascular dementia with behavioral problems as the psychiatric diagnosis evaluated. The consult further documents R24's history "...nursing notes that patient [R24] has been reasonably calm although period where he will complain of pain or that he is not being changed but then denies problems when approached...some concerns about mood, repeating what staff has said. On interview patient is paranoid about nursing, believes they are intentionally trying to harm him. Reports main problem is problems with being cleaned after defecation - nursing reports that he complains of defecation but no stool." The consult recommended a trial with antipsychotic such as Risperdal 0.5 milligrams (mg) at bedtime (hs) to help with paranoia and agitation. On 07/21/22 at 09:48 AM, review of R24's record indicated the physician ordered Risperidone tablet 0.5 mg for paranoia and agitation on 05/13/22. Review of R24's care plan did not document non-pharmacological interventions for paranoia and agitation. On 07/21/22 at 01:50 PM concurrent record review and interview with UM2 was done. UM2 reported that R24 was prescribed Risperidone due to paranoia and agitation, R24 thinks someone is trying to harm him and yells, shouts and is combative when provided care. UM2 reported examples of non-pharmacological interventions provided are reorienting him with	4 174	Potential for isolation / Psychosocial issues that include observations for feelings of isolation, sadness or feeling alone or lonely, difficulty of adjustment to new environment, lifestyle or homelike environment and to address any behaviors that are observed or the resident exhibits. This care plan will be separate from the covid-19 infection care plan. Started 08/11/22-Ongoing "Based on the CAAS that are triggered, MDS coordinator will ensure that an appropriate care plan will be in place for new admissions/readmissions and for all comprehensive assessments. Care plans will be reviewed during quarterly IDT meetings to ensure that the Care plans are still appropriate. Start 08/15/22-Ongoing "The MDS will conduct monthly QA Audits on Care plans to ensure that all triggers that need to be addressed are Care Planned. Start 08/31/22-Ongoing "HN and LN will follow the care plan and document observations in the behavior monitoring log related to new admissions/readmissions feeling isolated, sad, lonely, and having difficulty in adjusting to the new environment/quarantine/isolation. Start 08/15/22-Ongoing HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(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
4 174	Continued From page 3 reality, praising R24, and divert his attention such as watching television. Inquired if non-pharmacological interventions were documented in R24's CP, UM2 stated "It is not care planned for agitation or paranoia." On 07/22/22 at 10:07 AM concurrent record review and interview with Director of Nursing (DON) was done. Inquired with DON if R24's care plan includes non-pharmacological interventions to target the behaviors listed for the use of Risperidone, DON confirmed non-pharmacological interventions were not documented in the care plan and further explained "...it should be included in the care plan..." along with the psychotropic medication targeting specific behaviors. Review of the facility's policy and procedure on psychotropic drug use, policy number "ORNUR0009", with an effective date of 09/01/18 documents: "E. Interdisciplinary Care Plans... 1. The care plan must have specific problems stated what symptoms or behaviors are being addressed. 2. The care plan must be specific, individualized and have measurable goals with a time frame for evaluation. 3. Specific interventions include. a. Behavior modifications and management techniques to be used for situations (non-pharmacological interventions). b. Monitoring of behavior and side effects on BIMFR [Behavior/Intervention Monthly Flow Record] c. Which staff is to care out the intervention(s) 4. Care plans will be individualized to reflect resident preference and family input as	4 174	"MDS will perform a monthly Care plan audit that includes the Behavior care plan / Isolation Care Plan / psychosocial care Plan. In addition, for Comprehensive Assessments, care plans triggered by CAAS will also be reviewed to ensure their appropriate goals and interventions are in place. Start 08/31/22-Ongoing "Findings of this audit will be reviewed with HNs/SRNs/DON at the monthly Nurse Manager□s Meeting. Start 09/02/22-Ongoing "MDS will submit audit reports to the DON to report at the quarterly QAPI meeting. Start 11/22/22□Ongoing. (Audit plan will be discussed at the next QAPI meeting on Start 08/16/22-Ongoing HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS) WILL IMPLEMENT CORRECTIVE ACTIONS FOR RESIDENT #24 AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "Resident #24 care plan for paranoia and agitation was reviewed and updated to include non-pharmacologic interventions on 08/11/22. Completed 08/11/22 "Resident has sig change □ mood and behavior on Psychotropic meds, with Stage 4 pressure sore on Right heel. IDT met, reviewed and updated care plan on 08/11/22. Completed 08/11/22 "IDT conference call with family and resident via Zoom was held on 08/11/22. Completed 08/11/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(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
4 174	Continued From page 4 appropriate and feasible. "	4 174	HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS) WILL ASSESS OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS DEFICIENT PRACTICE, INCLUDING: "HN, SRN, DON, and SW will identify all residents with any psychotropic medications. Start 08/15/22□Completed 09/04/22 "HN and SW will review care plan for residents identified receiving any psychotropic medications to ensure person-centered, non-pharmacological interventions are in place. Start 08/15/22□Completed 09/04/22 HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), LICENSED NURSES (LN), AND MINIMUM DATA SET NURSE (MDS) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: "HN, ED will educate LN during shift reports to update care plans for residents with new orders for psychotropic medications, including orders obtained from Geri-psych consult recommendations. Care plans need to include non-pharmacologic interventions. Start 08/16/22□Completed 09/04/22 "HN will consult with SW on residents with psychotropic medications and their behaviors. SW will refer back to the social	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(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
4 174	Continued From page 5	4 174	history and speak with family or responsible party to gather information specific to resident□s behaviors along with appropriate and effective non-pharmacological interventions and strategies used in the past. Start 08/15/22-Ongoing "HN and SW will develop/update behavior care plan incorporating family□s suggestions and resident□s current state and will include person-centered non-pharmacologic interventions. Start 08/15/22-Ongoing "LN, HN, SRN will input non-pharmacological interventions in PointClickCare (PCC) behavior monitoring and document behaviors in PCC monitor log every shift. Start 08/15/22-Ongoing "HN will ensure that MDS coordinator/IDT will review and update care plans during quarterly IDT Conference meetings, to ensure that Care plans address individual, person-centered non-pharmacologic interventions and determine whether the care plan is still appropriate. Start 08/15/22-Ongoing HEAD NURSE (HN), NURSING SUPERVISORS (SRN), DIRECTOR OF NURSING (DON), SOCIAL WORKER (SW), AND QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING: "HN, SRN and SW will perform monthly review of care plans for residents receiving psychotropic medications that person-centered non-pharmacologic interventions are in place. Start	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(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
4 174	Continued From page 6	4 174	08/31/22-Ongoing "HN/SRN will submit findings to DON to report to quarterly QAPI Committee. Start 08/31/22	
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, interview, and record review, the facility failed to ensure that the Pneumococcal vaccines (medication given to protect an individual from pneumonia, a lung infection) was properly stored in the nursing unit's refrigerator. This deficient practice could potentially render the Pneumococcal vaccines inactive and affect residents needing protection from pneumonia. Findings include: On 07/21/22 at 09:53 AM, an observation of a nursing unit's medication refrigerator was made. The "DAILY TEMPERATURE RECORD MEDICATION REFRIGERATOR" log was checked and the temperature documented for the day shift was 40 degrees Fahrenheit. The proper range identified on the log was documented as "36-40 DEGREES." The Pneumococcal vaccines were kept in a compartment on the refrigerator door that the State Agency (SA) took a few minutes to access because of the difficulty to take them out of the enclosed section. On 07/22/22 at 07:56 AM, a review of the Centers	4 194	HEAD NURSE (HN), NURSING SUPERVISOR (SRN), DIRECTOR OF NURSING (DON), WILL IMPLEMENT CORRECTIVE ACTIONS (FOR 2MAKAI) AFFECTED BY THIS PRACTICE, INCLUDING: "2 Makai HN immediately relocated vaccines (Pneumococcal) found stored on refrigerator door to the middle shelf of the refrigerator. Completed 07/22/22 "HN placed signage on top of the refrigerator to remind all license nurses to Store all vaccines on the middle shelf at all times Completed 07/22/22 HEAD NURSE (HN), LICENSED NURSES (LN), NURSING SUEPRVISOR (SRN), TEMPORARY ASSIGNED (TA), EDUCATION NURSE (ED), DIRECTOR OF NURSING (DON) WILL ASSESS OTHER RESIDENTS HAVING HE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING: "HNs of the other two units (2Mauka and 3 Makai) checked their medication refrigerator for vaccines to ensure proper	9/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(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
4 194	Continued From page 7 for Disease Control and Prevention's (CDC) website, "Vaccine Storage and Handling Resources" at https://www.cdc.gov/vaccines/hcp/admin/storage/index.html, that produced a storage and handling fact sheet for vaccines, "Storage Best Practices for Refrigerated Vaccines-Fahrenheit (F)" that stated, "Don't put vaccines on door shelves or on floor of refrigerator." On 07/22/22 at 08:49 AM, a concurrent observation and interview were made with Unit Manger (UM)2 at the nursing station. The refrigerator temperature logged for the day shift was 40 degrees Fahrenheit and was verified by UM2. SA showed UM2 the location of the Pneumococcal vaccines on the refrigerator door and she agreed that the temperature would not be consistently held if the vaccines are stored on the shelf of the refrigerator door. UM2 moved the location of the Pneumococcal vaccines to the middle shelf inside of the refrigerator.	4 194	storage on middle shelf. No vaccines found stored on door. Completed 07/22/22 "DON shared at Oahu Region Pharmaceutical & Therapeutics Committee regarding proper storage of vaccines. Medical Director recommended no medications and vaccines to be stored on the refrigerator doors. Completed 08/02/22 "HNs placed signs on medication refrigerator to remind LN. Completed 08/02/22 HEAD NURSE (HN), LICENSED NURSES (LN), SUPERVISOR NURSE (SRN), TEMPORARY ASSIGNED (TA), EDUCATION NURSE (ED), DIRECTOR OF NURSING (DON) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: "ED, HN, SRNs, and DON revised Medication Storage policy and protocol (P&P) to include storage of vaccines in the middle shelf. Completed 08/12/22 "ED, HN, SRNs will educate LN during shift reports regarding revised Medication Storage P&P to properly store vaccines on middle shelf and continue checking/documenting refrigerator temperatures every shift. Start 08/16/22□Completed 09/04/22 "LN to store vaccines on middle shelf of medication refrigerator. Start 07/23/22-Ongoing "HN, ED and SRN/TAs will perform audits of all unit refrigerators to ensure that all medications/vaccines are properly stored and appropriate temperatures are maintained. Start 08/06/22□Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(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
4 194	Continued From page 8	4 194	HEAD NURSE (HN), SUPERVISOR NURSE (SRN), EDUCATION NURSE (ED), DIRECTOR OF NURSING (DON), AND QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) WILL MONITOR CORRECTIVE ACTIONS TO ENSURETHE EFFECTIVENESS OF THESE ACTIONS, INCLUDING: "HNs, SRN, ED will perform audits to check that vaccines are stored in the middle shelf of the medication refrigerators and that appropriate temperatures are maintained. Audits will be submitted to DON. Start 08/31/22 -Ongoing "Audit Plan to be shared at the next QAPI meeting. Completed 08/16/22 "Findings of audits will be submitted to the quarterly QAPI Committee meeting. Start 11/22/22-Ongoing	
4 243	11-94.1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to secure a storage room located on the 2 Makai nursing unit. As a result of this failure, the facility put the residents at risk for accident hazards. Findings include: During an observation on 07/19/22 at 10:30 AM, the storage room located on 2 Makai nursing unit	4 243	HEAD NURSE (HN), NURSING SUPERVISOR (SRN), TEMPORARY ASSIGNED NURSE (TA), LICENSED NURSE (LN) WILL IMPLEMENT CORRECTIVE ACTIONS FOR 2MAKAI STORAGE ROOM AFFECTED BY THIS PRACTICE, INCLUDING: "Storage door lock fixed. Completed 07/19/22 "Head nurse placed signage on the door	9/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(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
4 243	Continued From page 9 was not locked/secured and there was no staff in the immediate vicinity to prevent unauthorized entry to the room. The storage door had a keypad lock installed but the door latch was taped open to prevent the door from being locked. Observer was able to enter the room by just pushing the door open. A review of hazardous contents of the storage room were the following: Hydrogen Peroxide Solution, 3% USP 10 Volume, (4) 16 fluid ounce bottles, Aloe Vesta Daily Moisturizer containing Dimethicone 3% active ingredient, and inactive ingredients water, petrolatum, glycerin, steareth-2, cetyl alcohol, benzyl alcohol, laureth-23, magnesium, aluminum silicate, carbomer, potassium sorbate, sodium hydroxide, Aloe barbadensis leaf powder, Fresh Moment Mouthwash labeled; in case of accidental ingestion, seek professional assistance or contact a Poison Control Center immediately, (5) 4 fluid ounce bottles. During observations on 07/19/22 at 10:40 AM, two residents were noted be self-propelling their wheelchair pass the storage room, alone with no staff in the immediate vicinity to prevent them from entering the storage room and having access to the hazardous contents as previously mentioned. On 07/19/22 at 10:50 AM, Unit Manager (UM) 2, acknowledged that the storage room should have been locked/secured and stated that they would immediately get it fixed.	4 243	to keep door closed/locked at all times. Completed 07/19/22 "HN reminded staff during shift reports that storage room need to be locked to prevent unauthorized individuals, including residents, from entering and having access to hazardous contents. Completed 07/19/22-7/22/22 HEAD NURSE (HN), LICENSED NURSES, NURSING SUPERVISOR (SRN), TEMPORARY ASSIGNED NURSE (TA) AND OPERATIONS & MAINTENANCE (O&M) WILL ASSESS OTHER STORAGE AREAS HAVING THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE, INCLUDING: "Storage doors on the two other resident units were checked. Both had functional locks and doors were locked. Completed 07/19/22 "Facility-wide doors and locks were checked by O&M to ensure doors are locked/secured and door latches were not taped or stuffed with material to prevent locking. Completed 07/19/22 "SRN/TA, HN, and LN will do random rounds to check storage door on shift assignment. Start 07/19/22-Ongoing HEAD NURSE (HN), LICENSED NURSES (LN), NURSING SUPERVISOR (SRN), OPERATIONS & MAINTENANCE (O & M) WILL IMPLEMENT MEASURES TO ENSURE THAT THIS PRACTICE DOES NOT RECUR, INCLUDING: "HNs and SRN/TA will remind staff regarding the importance of keeping storage doors closed/locked for residents safety, during shift reports.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALUHIA	1027 HALA DRIVE HONOLULU, HI 96817

(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
4 243	Continued From page 10	4 243	Start 07/19/22□Completed 07/22/22 "All staff/employees to follow storage door protocol. Start 07/19/22-Ongoing "HN, SRN/TA, LN, and O & M will conduct audits to ensure that storage doors will be kept closed/locked at all times by checking storage rooms are locked, doors are properly functioning and fixed as appropriate, and door latch is not stuffed or taped. Start 08/01/22-Ongoing HEAD NURSE (HN), NURSING SUPERVISOR (SRN), DIRECTOR OF NURSING (DON) WILL MONITOR CORRECTIVE ACTIONS TO ENSURE THE EFFECTIVENESS OF THESE ACTIONS, INCLUDING: "HNs and SRN will monitor staff compliance and submit audit findings to DON. Start 08/31/22 - Ongoing "O&M will submit audit findings to Administration. 08/01/22-Ongoing "Audit findings will be reported at the QAPI Committee. Start 11/22/22□Ongoing. (Audit plan will be discussed at the next QAPI meeting on Completed 08/16/22)	