STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. BUILDING _____ B. WING _____	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

(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 A recertification survey was conducted by the Office of Health Care Assurance on 07/28/23. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. A complaint and a facility reported incidents were investigated, Aspen Complaint and Incident Tracking (ACTS) #10412 and #10399. Deficient practice related to accidents were identified related to ACTS #10399. Survey Dates: 07/25/23 to 07/28/23 Survey Census: 58 Sample Size: 18	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		9/11/23

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

Electronically Signed | 08/28/2023

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the resident's right to a dignified existence for four residents (Resident(R)65, Anonymous Resident (AR)1, AR2, and AR3). R65 reported staff did not respond to the resident's activated call light or assess/acknowledge the resident if staff could not immediately assist the resident for 30-45 minutes while on isolation precautions. Observations and/or interviews with AR1, AR2, and AR3 confirmed call lights were not being addressed in a timely manner despite the presence of staff. As a result of this deficient practice, the residents are at risk for potential physical and psychosocial harm. Findings include:	F 550	1. Administrator was unable to meet and follow up with anonymous residents to discuss call light response times. Residents #65 has been discharged. Staff members were counseled and inserviced in answering call lights appropriately and timely by the DON/designee. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by the alleged practices. 3. Call lights timeliness and responses were discussed with the Resident Council President by the Administrator. Facility staff were inserviced regarding answering	

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F 550	Continued From page 2 On 07/28/23 at 08:52 AM reviewed the intake number (#)10399 from the Aspen Complaints Tracking System (ACTS). Complaint received to the Office of Healthcare Assurance (OHCA) on 07/03/23 via telephone. R65 reported that on admission the resident in isolation for 10 days due to being positive for COVID-19 and during that time, the resident had to wait 30-45 minutes for staff to respond and address the resident's needs. R65 alleged that even after the resident completed the isolation period, staff continued to not respond to the resident's call light or address the resident (if staff was unable to immediately assist the resident) in a timely manner. R65 was able to see staff walking by his/her room, but they did not respond to or address the resident. The State Agency (SA) sampled three residents related to ACTS #10399 1) On 07/25/23 at 12:31 PM, observed AR1 call light had been activated. AR1 was in bed with the bedside table in front of the resident and was eating lunch. This surveyor observed multiple staff walk past the resident's room before the call light was acknowledge by staff at 12:52 PM. From 12:31 PM to 12:52 PM, this surveyor observed a CNA look up at the call light alert directly outside of AR1's room then entered a room directly across AR1's room; a licensed nurse exited a room two doors down from the resident; sanitize equipment in the hallway and did not check in with AR1, two other CNAs walked past R19's room and proceeded to assist other residents; and two other licensed nurses seated at the nurses station doing paperwork. All staff observed did not acknowledge or check in to see what AR1 needed assistance with. AR1 expressed that he/she is aware that staff are busy but feels frustrated that staff did not check in to	F 550	call lights appropriately and timely by the DON/designee. Inservices will be ongoing as needed. 4. The RCM/designee will monitor compliance with call light response through observation round audits weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved.	

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F 550	Continued From page 3	F 550		

see what the resident needed and stated "Good thing I didn't fall or anything, it would've taken them that long to realize it."

Review of AR1's most recent Minimum Data Set (MDS) Section C- Cognitive Function documented a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident cognition is intact and was alert and oriented to person, place, time, and situation during the interview.

2) During an interview with an AR2 on 07/26/23 at 11:22 AM, AR2 reported having to wait up to 30 minutes for assistance and/or staff to acknowledge the resident despite being able to see staff pass by the resident's room. AR2 recalled activating the call light, seeing staff walking past the room, and staff did not address the resident or the resident's needs. AR2 reported at times, he/she needed help reaching an item on the bedside table and other times the resident had a bowel movement and required assistance with changing his/her briefs. AR2 reported this issue happened on all shifts. AR2 felt as if staff were intentionally ignoring the resident and the resident's needs and staff should have acknowledge the resident and/or assessed the urgency of the resident's needs. AR2 felt that CNAs will not respond to the call light if it is not their resident, or it is not their section. AR2 reported that if your CNA is on break you are going to have to wait until they come back, and if they just went on break and you need to be changed, you will have to wait the entirety of the staff's break before staff respond to or attend to the resident's needs.

Review of AR2's most recent Minimum Data Set

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F 550	Continued From page 4 (MDS) Section C- Cognitive Function documented a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident cognition is intact and was alert and oriented to person, place, time, and situation during the interview. 3) On 07/25/23 at 02:34 PM, conducted an interview with AR3. The resident stated it is common to wait 25 minutes or more after activating the call light before staff comes in to acknowledge the resident. AR3 stated it has happened on all shift and staff are visible in the hall, but do not acknowledge or go into the resident's room to see why the resident activated their call light. Review of AR3's most recent Minimum Data Set (MDS) Section C- Cognitive Function documented a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident cognition is intact and was alert and oriented to person, place, time, and situation during the interview.	F 550		
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents,	F 577		9/11/23

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F 577	Continued From page 5 and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure the most recent survey results and plan of correction post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. Finding includes: On 07/27/23 at 12:15 PM, while on the lower unit this surveyor was unable to locate the facility's posting of the most recent survey results. At 12:19 PM, conducted an interview and observation of the most recent survey results with the Director of Nursing (DON). Informed the DON that this surveyor was unable to locate the most recent survey results. The DON escorted this surveyor into the main dining room (lower unit) and showed this surveyor the survey results binder which was in a corner of the dining room near the entrance to the rehab room. Only residents and family in that corner of the dining room would be able to visibly see the results binder. There was no clear indicator on the	F 577	1. Signage regarding the location of the survey results was placed at each nurses□ station and in the front lobby. 2. Facility residents have the potential to be affected by the alleged practice. 3. Administrator met with the Resident Council to ensure the residents knowledge of where the survey results were located. Facility staff were inserviced regarding where the survey results are located and where the signage was placed by the DON/designee. Inservices will be ongoing as needed. 4. Survey posting and signage locations will be monitored by the Administrator/designee by observation round audits weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3	

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F 577	Continued From page 6 bulletin board (where the results were located) to highlight the presence of the results. Also, when residents are assisted to the dining room, they are facing the TV and the bulletin board and results binder is to the resident's back. The DON confirmed the most recent survey results was not in a highly visible and prominent area that is accessible to the public as most visitors do not go into the lower dining room. At 12:21 PM, this surveyor and DON went to the upper unit dining room to view the most recent survey results which was in the upper unit dining area. After viewing the area, the survey results were posted and inquiring the likelihood of visitors seeing the most recent results binder, the DON confirmed it was not in a prominent, highly visible area for visitors.	F 577	months or until compliance is achieved.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		9/11/23

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F 584	Continued From page 7 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide a homelike environment for a resident (Resident(R)49) in hospice care, staff interrupting resident meals to administer medication, and residents receiving meals in the shared dining areas. R49's is a hospice resident and the resident's room walls were bare, no pictures, calendars, or any personal items, to ensure a homelike environment and equipment (not in-use) was being stored in the room. Resident's meals were left on trays while dining in the main dining room on both units (Unit 1 and Unit 2) throughout the survey. As a result of this deficient practice the residents are potentially at risk of	F 584	1. Current residents were questioned as to their preference regarding meals on trays by the Activity Director. Care plans were updated as needed. Resident #45 was evaluated for any ill effects related to medication administration during lunch. Medication times were adjusted as needed. The nurse involved in the medication administration during lunch was counseled and inserviced regarding the administration of medication during meals by the DON. Inservice will be ongoing as needed. Hospice resident #49 family was	

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F 584	Continued From page 8 psychosocial harm. Findings include: 1) Observations of the same five residents having lunch in the Unit 2 dining room on 07/25/23 at 12:17 PM; 07/26/23 at 12:15 PM; and 07/27/23 at 12:15 PM confirmed on the first two days 4 of 5 residents meals and beverages remained on trays and on the last day, all resident meals remained on trays. On all three days, staff was not observed asking residents if it was their preference to keep their meals and beverages on the tray. Resident's meals remaining on trays for the duration of the mealtime does not contribute to a homelike environment and should be removed to avoid an institutional environment. On 07/28/23 at 12:05 PM, conducted an interview with the Administrator. Inquired with the Administrator if it is the facility's practice to keep the residents' meals on a tray when eating in the unit dining room. Administrator stated it is the resident's choice if they want to eat their meals on the tray. Requested for documentation of the observed resident's preferences for their meals to remain on their trays. Administrator confirmed there was no documentation that it was the observed resident's preferences for their meals to remain on their trays, in addition, the Administrator stated it was not the facility's policy to remove meals from the trays while eating in the unit's dining room. 2) Conducted observations of residents having lunch in the common dining room on Unit 1 on 07/26/23 at 12:21 PM and 07/27/23 at 12:13 PM. Observations of residents in the dining room on	F 584	contacted and encouraged to bring in personal items from home to make his room more home-like by the SW. Oxygen concentrators were removed and will be returned only when in regular use as needed. 2. Facility residents have the potential to be affected by the alleged practices. 3. New residents will be questioned as to their preference regarding meals being left on trays by the Activity Director/designee. Care plans will be updated as needed. Facility staff were inserviced regarding serving meals off trays by DON/designee. Inservices will be ongoing as needed. Licensed nurses were inserviced regarding appropriate timing of medication administration by the DON/designee. Inservices will be ongoing as needed. Social Services/designee will encourage new admissions to bring in personal items to make residents feel more at home. Current rooms were audited to ensure compliance. DON/designee inserviced IDT and direct care staff regarding creating a home-like environment for residents. Direct care staff were inserviced regarding removing extra unused or not in regular use equipment from resident rooms by the DON/designee. Inservices will be ongoing as needed. 4. RCM/designee will monitor compliance with meal service, medication administration during mealtimes and extra	

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F 584	Continued From page 9 07/26/23 documented all residents (7 of 7 resident) and on 07/27/23 (8 of 8 residents) meals remained on trays for the duration of their meals. Staff was observed delivering trays and did not inquire with residents if they wanted their meal and beverage to remain on the tray. Resident's meals remaining on trays for the duration of the mealtime does not contribute to a homelike environment and should be removed to avoid an institutional environment. 3) On 07/28/23 at 08:28 AM, conducted observations of Nursing Staff (NS)4 administering medications to R45. NS4 entered R45's room and the resident was eating breakfast. R45 was in the middle of chewing her food when NS4 interrupted the resident's meals and insisted the resident take her medications. R45 requested for NS4 to place the medication on to a napkin in front of the resident. NS4 declined. R45 requested with NS4 four more times and NS4 declined while maintaining eye contact with the resident. R45 was audibly irritated/upset and firmly stated, "Can you just listen to me?" NS4 complied. R45 proceeded to arrange the medication in order of size and took the medication (from largest in size to smallest). R45 took her time while taking the bigger tablets and appeared to have a little difficulty. After R45 took all the medication, NS4 pushed the resident's breakfast tray back in front of the resident. R45 did not continue to consume anymore of the meal and seemed upset. Throughout the interaction, NS4 did not give the resident the option of taking the medication later. At 08:55 AM, conducted an interview with R45. Inquired if the resident was going to continue eating breakfast. R45 stated that she was not	F 584	unused equipment in resident rooms by observation rounds and medical record audits weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved. Social Service/designee will monitor home-like environment through weekly observation round audits for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved.	

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F 584	Continued From page 10	F 584		

going to eat anymore and that she had lost her appetite after taking the medication. Inquired if NS4 interrupting her breakfast to take medications had anything to do with the resident losing her appetite. R45 stated that she has a hard time and does not enjoy taking pills and confirmed the interruption of her meal to take medication did affect her appetite and reported feeling upset by the interaction.

After administering R45's medication, NS4 went back to the medication care, prepared R50's medications, and interrupted the resident's breakfast to administer medications. NS4 did not give the resident the option of continuing the meal and taking the medications later.

4) Review of R49's Electronic Health Record (EHR) on 07/26/23 at 10:50 AM documented R49 is a 69-year-old male who was admitted to facility on 05/09/23. Review of the resident's Physician Orders documented on 06/10/23, R49 was placed on hospice services and a Do Not Resuscitate (DNR) order implemented. R49 qualified for hospice services which indicates the resident's physician made a clinical determination that the resident's life expectancy is six months or less if the terminal illness runs its normal course.

During an observation on 07/25/23 at 10:12 AM, observed R49 in bed sleeping. Observation of the resident's room did not appear homelike due to the wall decor consisting of three pieces of paper (with writing) and one plastic clock. R49's room appeared institutional due to no personalized wall decorations (pictures, mirrors, calendars, or any expression of what the resident likes, enjoys, or what is important in his/her life) or furniture. The only items in the room were a

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F 584	Continued From page 11 walker and a wheelchair. At 11:47 AM, a second observation of R49's room documented two oxygen concentrator machines were being stored in the corner of the resident's room and a suctioning machine/apparatus on the resident's nightstand. Both oxygen concentrators were not being used by the resident.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accurately assess one Resident (R)16 for functional limitations of the bilateral upper extremities (BUE). The deficient practice affected R16's range of motion (ROM) due to not receiving the care and treatment needed to maintain or improve his functional status. As a result, the care plan was not implemented, and the restorative care not provided. Findings include: During observations of R16 on 07/27/23 at 10:41 AM, R16 stated to the surveyor "I need to get these fixed" while holding up both hands showing the surveyor and the nurse. Both of R16's hands appeared to be contracted. R16 expressed wanting to call the doctor, but he/she did not have a personal phone and the phone facility provided phone does not work well. Surveyor inquired with the Registered Nurse (RN)38 if any referrals were made to the doctor to evaluate R16's contracted	F 641	1. Resident #16 was reassessed for ROM of upper extremities by therapy and treatment was rendered as needed. The MDS was updated to reflect the resident□s status. MDS Coordinator and Nurses involved were counseled and inserviced regarding documentation and accurate assessments by the DON/designee. Inservice will be ongoing as needed. 2. Facility residents have the potential to be affected by the alleged practices. 3. Current facility residents were reassessed for functional limitations/contractures and referred for therapy as needed. Care plans were updated as needed. Licensed nurses were inserviced regarding appropriate completion of contracture assessments by the DON/designee. Inservices will be ongoing as needed.	9/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. BUILDING _____ B. WING _____	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 641	Continued From page 12 hands (cross reference to F688 Increase/ prevent a decrease in range of motion/mobility). On 07/27/23 at 11:07 AM, reviewed R16's Electronic Health Record (EHR). The reviewed R16's most recent quarterly Minimum Data Set (MDS) quarterly with an Assessment Reference Date (ARD) of 05/29/23. Functional limitation in range of motion for BUE was coded as "no impairment", (limitation that interfered with daily functions or placed resident at risk of injury). On 07/28/23 at 09:28 AM, observed R16 in his bed reading the paper, both hands appeared very stiff, claw-like, and contracted. The resident stated, "My hands are so stiff, and I use to be able to play music." On 07/28/23 at 11:37 AM, conducted a concurrent record review and interview with the Director of Nursing (DON)1 and DON2. DON1 and DON2 reviewed R16's most recent quarterly MDS with an ARD of 05/29/23 and confirmed R16's BUE functional status was not accurately coded and did not reflect that the resident's hands were contracted. DON1 and DON2 confirmed the MDS affects what is included in the resident's care plan which in turns affects services received by the resident and R16's inaccurate MDS for functional status of the resident's BUE did not generate a care plan area and as a result the resident did not receive restorative care and/or the facility was not implementing interventions to decrease worsening of the resident's contracted hands.	F 641	4. RCM/designee will monitor compliance with Contracture assessments, Care plans and Therapy/Restorative referrals by medical record audits weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		9/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. BUILDING _____ B. WING _____	07/28/2023

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 657	Continued From page 13 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to update the care plan with new interventions to address two Resident's (R)14 and R16 of two residents in the sample had been refusing restorative care. The deficient practice negatively impacts the resident's functional capacity to prevent decline and maintain range of motion and mobility. Findings include:	F 657	1. Resident #14 was reassessed for hand contractures. Referral and treatment were made as needed. Family was advised of the Risk versus Benefit of her refusing treatment. The care plan was updated as needed. Nurses were inserviced regarding documentation of treatment and refusal of treatments by the DON/designee. Inservice will be ongoing as needed.	

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 657	Continued From page 14 (Cross Reference to F688 Increase/Prevent Decrease in Range of Motion/Mobility) On 07/25/23 at 3:10 PM, observed R14 in her bed with bilateral upper extremities (BUE) (hands) and bilateral lower extremities (BLE) were contracted. Noted a long red roll on the nightstand and two booties on the bedside table. On 07/27/23 at 4:48 PM, observed R14 with bilateral hands fisted. Noted carrot on the nightstand and the boots on the bedside table. At 05:05 PM asked Registered Nurse (RN)15 if R14 participates in any range of motion exercises. RN15 Stated, we try, but she refuses, when we try to clean her hands, she gets mad. On 07/28/23 at 09:09 AM, observed R14 lying in bed with bilateral fists tightly closed. knuckles appeared white. Observed orange/red hand roll were on nightstand and bilateral boots were on the bedside table. At 09:20 AM, observation with RN38, attempted to open R14's hand. RN38 warned me that she will scream. When she asked R14 to open her hand and moved close to it, R14 immediately pulled it away and started swearing. Asked RN38 who trims her nails, she responded that the CNA's trim her nails. Review of R14's Electronic Health Record (EHR) on 07/27/23 at 04:26 PM. Review of R14's quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 06/12/2023, documented in Section C: Brief Interview for Mental Status (BIMS) score was an 8 indicating the resident has moderately low cognitive functioning and the resident's active diagnosis is hemiplegia, the resident is unable to move her	F 657	Resident #16 was seen by the physician and referral for lower limb contractures was made. The care plan was updated as needed. Nurses were inserviced regarding documentation of treatments and updating care plans to reflect resident□s status by the DON/designee. Inservice will be ongoing as needed. 2. Facility residents have the potential to be affected by these alleged practices. 3. The IDT and licensed nurses were inserviced regarding comprehensive care plans and updating care plans by the DON/designee. Inservices will be ongoing as needed. Current facility residents were reassessed for contractures and referred for therapy as needed. Current residents were assessed for refusal of interventions and those identified received risk versus benefit analysis by the RCM/designee. Care plans were updated as needed. 4. DON/designee will monitor compliance with contracture assessments, comprehensive care planning and updating by medical record audits weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved.	

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F 657	Continued From page 15	F 657		

legs. Review of R14's care plan documented interventions for the resident's risk of contractures included:

--Facilitate BUE range of motion exercises during routine care. Put on left soft elbow splint for four hours per shift, monitor for any pain, skin breakdown, and advise charge Nurse.
--Lower extremity positioning using Heel lift Boot daily in bed for four hours every shift. Stretch left knee towards extension then apply boots on both feet. Ensure anti-rotation block is on the lateral aspect of boot. apply rolled pillow or towel on the outside of left knee to keep left leg from rotating out wards. Perform skin check after removing boot.
--Right and left carrot schedule provide ROM prior to and after use of carrot, check skin integrity before and after, notify Nurse for any redness, swelling, skin breakdown or pain, apply four hours per shift, daily 8 am-12 noon, 4 PM to 8 PM and 12 mid to 4 am. please make sure carrot is securely applied between resident's palm and all fingers, especially right hand.
--Provide routine range of motion (ROM) with all daily care.

A second review of R14's EHR on 07/28/23 at 11:11 AM was conducted. A progress note written on 07/07/23 at 02:42 PM documented, "Resident refused hand care - screamed very loudly whenever I attempted to touch her hands. Will endorse to next shift." This progress note was the only documentation in the EHR progress notes of R14's refusal of care.

Multiple observations were made of R14's resistance to care and attempts to implementation interventions for restorative care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 657	Continued From page 16	F 657		

were rejected by the resident. Despite the resident's refusal, staff did not consistently document the resident's refusals and R14's care plan was not updated to include the resident's refusal or other potential interventions which could potentially or do work for R14 with implementing interventions for restorative care.

2) Conducted an observation on 07/27/23 at 10:41 AM, of R16 in bed with the resident's legs elevated with both feet resting (in direct contact with) the bed mattress.

During observations on 07/28/23 at 09:28 AM, R16 was in bed reading the paper and both hands appeared to be stiff and contracted. The resident did not have an air mattress both legs were in direct contact with the bed mattress and the resident had a dressing on the right small toes. Asked R16 if staff have been applying any type of splints or stretching exercises for both legs. R16 replied, "No".

On 07/26/23 at 1:00 PM, reviewed R16's care plan for risk of contractures. The care plan documented an intervention to facilitate BLE (bilateral lower extremities) PROM (Passive Range of Motion)/ROM (Range of Motion) exercises during routine care every shift and to place foam bolster under resident's thighs to facilitate prolonged stretching of bilateral knees towards flexion every shift (day, evening, and night).

On 07/28/23 at 09:36 AM, during an interview with the physical therapist (PT), inquired as to the type of restorative care R16 is receiving. PT stated nursing is working on a referral for R16 to see a specialist because of the type of lower

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 657	Continued From page 17 extremity contractures the resident is presenting with, legs are stiff and straight and physical therapy services are on to complete the resident's assessment. Physical therapy staff attempted stretching R16, but the resident was having too much pain, staff attempted to bolster both legs but it did not work. PT reported that nursing is working on a referral to an outside specialist that can provide more mechanical treatment that is unavailable at the facility and will continue to work with R16. On 07/28/23 at 10:10 AM, a request was made with the Administrator for a copy or documentation of R16's referral to a specialist to address the resident's unique type of lower extremity contractures which the facility's physical therapy staff could not properly address and/or treat. This surveyor did not receive the requested or relevant documentation.	F 657		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure one resident sampled (Resident (R)2) sampled received professional standard quality of care. R2 was	F 684	1. Resident #2 has been discharged. Nurses involved with her/his care have been inserviced regarding appropriate assessments and timeliness of referrals	9/11/23

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 684	Continued From page 18 readmitted to the facility on 07/11/23 from an acute hospital with an ostomy bag. The facility did not develop care plans, which drives the care of residents for malnutrition, pain, and prevention of pressure injury/pressure ulcer. On admission, the physician identified R2 to be at risk for malnutrition, R2 was not assessed by the Dietician until 9 days after admission when contacted by the facility due to R2's poor oral intake, refusing meals, and having a significant weight loss of 12.09%. R2 was not ordered pain medication for severe pain (7-10 on the Numeric Pain Rating Scale) despite R2 reporting a pain score of 8 on two separate documented occasions, and a care plan was not developed for pain. R2 was not administered pain medication prior to or after treatment of a PU during which the resident verbally and non-verbally expressed pain and during another incident when nursing staff was informed of the resident's request for pain medication. R2 had a decline in mobility which resulted in a decrease of mobility functioning and R2 remained in bed, increasing the risk of developing a new pressure injury/ulcer (PI/PU). A care plan was not developed in response to R2's change in mobility functioning to prevent a new PI/PU and was not developed after staff first identified the sacral PI to prevent it from worsening. As a result of this deficient practice, R2 experienced physical harm and a high potential for psychosocial harm. Findings include: Observations were made of R2 on 07/25/23 at 10:20 AM, 12:10 PM, 01:15 PM, 02:31 PM; 07/26/23 at 09:10 AM, 11:17 AM, 01:35 PM, 03:23 PM; and on 07/27/23 at 08:55 PM, 09:30 AM, 10:15 AM, and 12:45 PM. During these	F 684	and treatments related to nutrition, pain, and skin integrity by the DON/designee. 2. Facility residents have the potential to be affected by these alleged practices. 3. Current residents were reassessed for nutrition status, pain management, skin integrity/interventions, treatment, and documentation. Assessments, treatments, documentation, and care plans were updated as needed. Licensed nurses, CDM/RD and IDT were inserviced regarding skin integrity, pain management and nutritional assessments, implementing care plan interventions/treatments and documentation by the DON/designee. 4. RCM/RD/designee will monitor compliance with skin integrity, pain management and nutritional assessments, implementing care plan interventions/treatments and documentation by medical record audits weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved.	

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 684	Continued From page 19	F 684		

observations, R2 was lying flat on his back, both heels were in direct contact with the air mattress, there was an observable indentation in the air mattress directly under R2's heels, and there were no indication interventions to turn, reposition, or use a wedge/pillow to off-load high contact points were implemented. Observations of R2 with staff present, noted staff did not attempt to reposition the resident or explain to the resident why off-loading the PU was necessary and/or beneficial to prevent worsening of current PU and prevent any new PU.

During the observation on 07/25/23 at 12:10 PM, Nursing Staff (NS)38 and a hospice nurse, who was evaluating the resident for hospice services, were providing treatment to R2's PU and changing the dressing. Observed R2 wincing, grimacing, and squeezing his eyes tightly in pain while turning onto his side, also observed that the resident required the assistance of NS38 to turn and could not have turned on his own. While NS38 provided treatment to the wound bed, R2 stated "Sore" and "Ouch" in response to any contact with the wound bed. While R2 laid on his side, redness was observed on the outside portion of the resident's right foot. NS38 inquired with R2 if he had any pain, and the resident responded with "Sore". At the time, it was unknown if R2 had been premedicated prior to the dressing change to mitigate amount of pain the resident would experience. After the dressing change, this surveyor did not observe NS38 administer pain medication to alleviate the resident's pain. Inquired with NS38 regarding R2's course of treatment at the facility. NS38 stated R2 was a long-term resident at the facility and had recently been readmitted to the facility on 07/11/23 with an ostomy bag (an external pouch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 684	Continued From page 20	F 684		

used to catch urine or stool) due to a portion of the intestine twisting around it's blood supply, sigmoid volvulus). NS38 reported that prior R2's discharge, the resident was independent in most areas of care, could ambulate on his own, had a good appetite, and would spend most of the day in the unit dining room with other residents. However, on readmission, R2 hardly ate, continued to lose a significant amount of weight, could no longer walk independently, and just wanted to stay in bed. As a result of these changes, the contracted hospice nurse was there to assess R2 was an appropriate candidate for hospice services. Later in the day, this surveyor was informed that R2 was accepted and admitted to hospice services.

On 07/26/23 at 09:55 AM, conducted a review of R2's Electronic Health Record (EHR). R2 was readmitted to the facility on 07/11/23 with a diagnosis which included a Sigmoid Volvulus, NSTEMI, hypokalemia, epilepsy, diabetes mellitus type 2, and a recent ileostomy resulting in the placement of an ostomy bag. Review of R2's care plan documented a care plan was not developed for the prevention of PU, decline in Activities of Daily Living (ADLs), pain, and risk for malnutrition.

---Record review related to R2's pressure include review of but not limited to multidisciplinary notes, physician orders, and assessments. No care plan was developed for prevention of PU. Review of nursing Admission Assessment on 07/12/23 at 08:00 AM documented under "Skin", R2 did not have any skin alterations. A skin assessment on 07/21/23 at 04:14 PM, documented in a comment, "Comments: Pressure wound to

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	125046	A. BUILDING _____ B. WING _____	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 684	Continued From page 21	F 684		

sacrum, Tx (treatment) in place, Triad and silver alginate.", on 07/25/23 at 05:32 PM, " Comments: Pressure wounds to sacrum persist and worsening. Tx (treatment) in place, Triad around wound border, silver alginate on wound bed and cover w/abd (abdominal) dressing."; and 07/26/23 at 10:35 AM, documented the sacrum wound as unstageable Pressure Injury, obscured full-thickness skin and tissue loss, measuring 4 cm in length 8.5 com in width, and 0.3 cm in depth. 100% eschar with attached edges and moderate serosanguinous drainage, the surrounding peri area is described as non-blanchable erythema: red. it documents that R2 does not have pain associated with the wound. Review of the physician orders documented the air mattress was ordered and applied on 07/20/23. Review of the Braden Scale for Predicting Pressure Sore Risk documented three assessments were completed. On 07/12/23 at 02:26 AM, Braden score was 21 indicating the resident was NOT AT RISK; on 07/19/23 at 01:25 AM Braden score was 14 indicating the resident was Moderate Risk, despite staff documenting a quarter sized dark non-blanchable discoloration to the resident's sacrum, a previous PU in the same spot in 2019 due to moisture; and on 07/26/23 at 01:12 AM, R2 remained as a Moderate Risk despite having an open sacrum unstageable PU. Review of the Aloha Wound Care Nursing Facility Service consultation, on 07/20/23, documented R2's wound was located on the sacrum. Wound previously occurred by pressure mechanism in March 2019 (healed). R2 was recently hospitalized on 06/17/23 to 07/11/23 for sigmoid volvulus and re-admitted to the facility. The wound occurred after admission per staff.

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 684	Continued From page 22	F 684		

---Record review related to R2's pain include review of but not limited to multidisciplinary notes, physician orders, and Medication Administration Record (MAR). No care plan was developed for pain. Review of physician orders related to PUs documented only Acetaminophen 650 mg (oral and suppository) were ordered to treat R2's mild to moderate pain. No medication was ordered to treat severe pain. On 07/12/23, a physician's order documented, Nutrition risk, Special Instructions: At risk for malnutrition. Review of the July 2023 Medication Administration Record (MAR) documented R2 was administered Acetaminophen 650 mg four times (since readmission on 07/11/23).

- 07/23/23 at 04:18 AM, pain 8 of 10 "a whole lot of pain", located in the buttock
- 07/23/23 at 01:38 PM, pain 5 of 10, located in the bilateral lower extremities
- 07/23/23 at 08:10 PM, pain 5 of 10, located in the buttock
- 07/25/23 at 06:22 AM, pain 5 of 10, for general body pain

A progress note on 07/24/23 documented R2 refused therapy due to his/her pain level being an 8 out of 10, however, R2 did not have a medication order to treat the resident's severe pain. Review of NS38's progress note on 07/25/23 at 03:55 PM, NS38 documented R2 "denies pain", which contradicts this surveyor's observations and R2 verbalizing pain "sore" and expressing pain indicators (wincing, squeezing eyes closed tightly) while providing treatment to the PU. Also, on 07/27/23, after the Director of Nursing (DON)1 observed and assessed R2 and the resident reported pain, DON1 informed NS4 of R2's pain and request for pain medication, however, review of the MAR documented NS4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. BUILDING _____ B. WING _____	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

(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 684	Continued From page 23	F 684		

did not administer Acetaminophen 650 mg for pain as instructed by DON1.

---Record review of the EHR related to R2's nutrition include review of but not limited to multidisciplinary notes, physician orders, weights, and assessments documented there was a delay in addressing R2's risk for malnutrition, addressing R2's refusal of meals and potentially adding an appetite stimulant or other intervention, and the effects of untreated pain on R2's appetite, and the delay in identifying the resident significant weight loss. No care plan was developed for R2 related to the resident's risk of malnutrition related to the resident returning to the facility with a newly placed ostomy bag. A physician's order on 07/12/23 identified R2 was at risk for malnutrition. On 07/18/23 R2 was ordered and received 3 liters (L) of D5 1/2NS intravenous fluid (IV) on 07/18/23 for dehydration related to poor oral (PO) intake. On 07/11/23 (day of admission), R2 weighted 137 lbs. (pounds); 07/20/23 weight was 125.6 (11.4 lbs. loss in 9 days); and 07/24/23 weight was 121.4 lbs. (15.6 lbs. loss in 13 days). Although, there was a physician's order identifying R2 at risk for malnutrition on admission, the dietician did not assess the resident on admission to prevent R2 from experiencing malnutrition. The dietician was contacted via email on 07/20/23 to assess R2 after the resident had experienced a decline in ADLs, significant weight loss, received IV fluid for dehydration, and developed a new pressure injury. Progress notes documented a nutritional supplement was ordered on 07/20/23 to address the immediate issue, but the dietician did not come into the facility to conduct an in-person assessment of R2 until 5 days later (07/25/23). During that visit, the dietician documented R2 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. BUILDING _____ B. WING _____	07/28/2023

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 684	Continued From page 24	F 684		

experienced a significant weight loss of 12.09% since 07/11/23 (14 days after admission). Review of R2's intake of meals prior to the facility contacting the dietician from 07/11/23 to include 07/20/23, out of a total of 28 possible meals, R2 refused 10 meals, consumed 1-25% of 11 meals (staff documented resident had only eaten a couple of bites on more than one occasion), consumed 26-50% of 6 meals, and only one instance of R2 eating 51-75% of a meal.

---Record review of R2's EHR related to ADL decline included review of but not limited to the Minimum Data Set (MDS) and progress notes. The facility failed to identify R2's increased risk of PU due to a decline in the resident's mobility. Point of Care History documented R2 did not walk in room or out of unit starting on 07/13/23, prior to that the resident attempted but required 2+ person assist, extensive assist, or set-up. R2's discharge MDS with an Assessment Reference Date (ARD) of 06/14/23, prior to R2 discharge to an acute hospital, the resident required limited assistance from staff and was highly involved in the activity, staff provided guided maneuvering of limbs or other non-weight-bearing assistance for walking in the room, moving on the unit, bed mobility, transfer between surfaces (ex. bed to chair/wheelchair etc.), dressing, eating, toilet use, and personal hygiene. A nursing progress note written on 07/18/23 at 04:33 PM documented staff used a maxi lift to transfer R2 to and from the shower chair; 07/19/23 at 04:05 PM, R2 needed some help from staff with eating his meal; 07/24/23 at 04:42 PM, R2 requires 1 person assist for bed mobility, dressing, and personal hygiene care.

On 07/27/23 at 12:30 PM, conducted a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. BUILDING _____ B. WING _____	07/28/2023

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 684	Continued From page 25	F 684		

concurrent interview and record review of R2's EHR with the Director of Nursing (DON)1, then a subsequent observation of R2 with DON1 related to surveyor's concerns of the quality of care the resident received for risk malnutrition, prevention of PUs, pain, and ADL decline. DON1 reviewed R2's care plan and confirmed the current care plan did not include R2's risk for malnutrition, prevention of PUs, pain, or ADL decline on readmission from an acute hospital in accordance with professional standard of care. Inquired what would DON1 expect to see in a care plan to properly address prevention of a PU. DON1 stated R2 should be turned frequently, if the resident refuses staff can use pillows and wedges to off load the resident's weight on high-risk areas. The dietician should have been contacted shortly after R2 was re-admitted addressing the resident's malnutrition, newly identified skin issues, and the resident's refusal to eat. Inquired if the team could have considered administering an appetite stimulate for a decline in the resident's appetite. DON1 confirmed it could have been considered but was not brought up as an option. DON1 reviewed the Braden Scale for Predicting Pressure Injury assessments completed by nursing staff. DON1 reviewed the assessments and stated that staff did not properly complete the for and if staff had identified R2 would be occasionally moist, the score would have prompted a care plan for PU to be developed and R2's assessment completed after the opening on the PI, R2 should be High Risk and not Moderate Risk. Informed DON1 of my observation of R2 while NS38 was providing treatment of the PU. DON1 reviewed the MAR and confirmed R2 had not received pain medication prior to or after treatment of the sacral PU, despite multiple pain indicators expressed by

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	125046	A. BUILDING _____ B. WING _____	07/28/2023

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 684	Continued From page 26	F 684		

R2 and only had medication orders to treat mild to moderate pain and did not address severe pain. Informed DON1 of observations of R2's heels in direct contact with the bed and lying flat on the bed and requested for DON1 to assess the resident. At 12:55 PM, DON1 conducted a physical assessment of R2. DON1 observed R2's heels in direct contact with the mattress, the indentation of his heels on the air mattress, the outer part of R2's feet and heels were reddened, but blanchable and was at risk for developing a new PU. Also, on the bony prominence of R2's left ankle appeared to be the start of a sore and around the ankle, R2's skin was purple with extremely poor profusion, indicating the development of a PU. DON1 assisted R2 with turning so we could assess the resident's back. The bony prominence (spine, shoulder blade etc.) was in constant direct contact with the bed and were reddened indicating the resident had not been turned or repositioned to periodically off-load the areas. On the upper portion of the resident's back there were approximately four 1 inch (in.) by 1 in. patches of petechiae bruises. DON1 could not identify the source of or how the resident sustained those bruises. DON1 observed R2's non-verbal expressions of pain, assessed the resident's pain, asked R2 if he wanted medication for the pain, and R2 agreed. DON1 confirmed R2 appeared to be in constant pain, his pain was unmanaged, and pain most likely contributing to a decrease in ADL functioning and affecting the resident's appetite. DON1 and this surveyor went back to the unit nursing station where DON1 reported R2's pain to NS4 and requested that staff administer pain medication to R2. Later review of R2's MAR with another nursing staff on 07/28/23 confirmed NS4 had not administered pain medication to R2 as

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	125046	A. BUILDING _____ B. WING _____	07/28/2023

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 684	Continued From page 27 requested by DON1 and had not documented that R2 had refused NS4's attempt to administer the pain medication. After reviewing R2's EHR, inaccurate assessments of R2's risk for developing a PU on the Braden scale, and no care plan was developed and no interventions were implemented to prevent a new PI/PU DON1 confirmed R2's PI/PU was avoidable and R2's pain was not managed in accordance with professional standards of care.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §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 observation, interview and record review the facility failed to provide the resident (R)14 and R16 with the care and services to maintain and prevent the further decline in the Range Of Motion (ROM) in both residents hands	F 688	1. Resident #14 was reassessed for hand contractures. Referral and treatment were made as needed. Family was advised of the Risk versus Benefit of her refusing treatment. The care plan was	9/11/23

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	125046	A. BUILDING _____ B. WING _____	07/28/2023

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 688	Continued From page 28 and legs. The deficient practice affects the resident's psychosocial well-being and mobility. Findings include: (Cross reference to F657 Care Plan Timing and Revision) 1) Observation of R14 on 07/25/23 at 3:10 PM in bed with contracted bilateral upper extremities (BUE) (hands) and bilateral lower extremities (BLE). Noted a long red roll on the nightstand and two booties on the bedside table. Review of R14's Electronic Health Record (EHR) on 07/27/23 at 04:26 PM. Review of R14's quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 06/12/2023, documented in Section C: Brief Interview for Mental Status (BIMS) score was an 8 indicating the resident has moderately low cognitive functioning and the resident's active diagnosis is hemiplegia, the resident is unable to move her legs. Review of Physician orders documented a Point of Care (POC) task to clean both hands with soap and water, dry thoroughly, apply rolled towel to both hands with powder, once a day on Monday, Wednesday, and Friday 07:00 AM - 03:00 PM was ordered on 03/22/2023. During an observation on 07/27/23 at 4:48 PM noted R14 with bilateral hands fisted. Carrot on the nightstand and the boots on the bedside table. Noted carrot was not placed in R14's hand nor were the boots applied to the lower extremities. On 07/27/23 at 5:05 PM, asked Nursing Staff (NS)15 if R14 participates in any ROM exercises.	F 688	updated as needed. Nurses were inserviced regarding documentation of treatment and refusal of treatments by the DON/designee. Inservice will be ongoing as needed. Resident #16 was seen by the physician and referral for lower limb contractures was made. The care plan was updated as needed. Nurses were inserviced regarding documentation of treatments and updating care plans to reflect resident□s status by the DON/designee. Inservice will be ongoing as needed. 2. Facility residents have the potential to be affected by these alleged practices. 3. The IDT and licensed nurses were inserviced regarding comprehensive care plans and updating care plans by the DON/designee. Inservices will be ongoing as needed. Current facility residents were reassessed for contractures and referred for therapy as needed. Current residents were assessed for refusal of interventions and those identified received risk versus benefit analysis by the RCM/designee. Care plans were updated as needed. 4. DON/designee will monitor compliance with contracture assessments, comprehensive care planning and updating by medical record audits weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved.	

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F 688	Continued From page 29	F 688		

Stated, we try, but she refuses, when we try to clean her hands, she gets mad and yells and swears at the staff. When asked if the refusal by R14 to have treatment is documented anywhere. NS15 responded that the CNA's should be documenting in the record.

Observation of R14 lying in bed on 07/28/23 at 09:09 AM with bilateral fists tightly closed, and the knuckles appeared white. Noted the orange/ red hand roll (carrot) on the nightstand and the boots on the bedside table.

Surveyor asked NS38 if she can open R14's hands to inspect the skin on 07/28/23 at 09:20 AM. NS38 warned me that she will scream loud, just so you know. When she asked R14 to open her hand and moved close to it, R14 immediately pulled it away and started swearing. Asked NS38 who trims her nails, and she responded that the CNA's trim her nails during her personal care.

Physical therapist (PT) interviewed on 07/28/23 at 09:40 AM. When asked to discuss R14's plan of restorative care she explained. We tried the palm protector and the carrots. She was referred to a specialist for a surgical intervention to address the hand contractures. she wasn't a surgical candidate due to her heart condition. The staff has a program for her restorative care. We pick them up and check, to try the splints and they are checking the palm for cuts. She has the boots and sometimes she allows the staff to put the boots on. If she starts being combative, we are supposed to back off. We have tried different type of boots. We are trying to do our best.

EMR reviewed on 07/28/23 at 11:11 AM. Progress notes reviewed. Noted a nurses note

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	125046	A. BUILDING _____ B. WING _____	07/28/2023

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 688	Continued From page 30	F 688		

on 7/07/2023 at 2:42 PM. Resident refused hand care - screamed very loudly whenever I attempted to touch her hands. Will endorse to next shift. Nursing. Noted there was only one nursing note that R14 refused care.

Reviewed Care Plan (cross reference to F657 Care plan timing and revision).

Behavior Committee Review dated 06/21/2023 at 10:09 AM.
Resident continues Abilify (an anti-psychotic medication) 10 milligrams (mg) daily, she does have a diagnosis of Schizophrenia. She has been stable with no behaviors or mood. Will continue to monitor quarterly and as needed.

Director of Nursing (DON)1 and DON2 interviewed on 07/28/23 at 11:20 AM. Surveyor asked where the behavioral documentation is being done. DON1 provided the treatments administration history from 07/01/2023 to 07/28/2023 and the point of care history from 07/24/23 to 07/28/23. Reviewed the treatments administration history on 07/28/23 at 11:20 AM. Noted R14's behavior of resistive to care was documented one time on 07/13/23; 07/19/23; 07/20/23 and 07/26/23 of the 28 days.
Reviewed the point of care history and noted reviewed point of care (POC) history 07/24/23 to 07/28/23: Right and left carrot schedule provide ROM prior to and after use of carrot, check skin integrity before and after , notify Nurse for any redness, swelling, skin breakdown or pain, apply 4 hours per shift, daily 8 am-12 noon, 4 PM to 8 PM and 12 mid to 4 am. please make sure carrot is securely applied between residents palm and all fingers, especially right hand [Every Shift] to be done by the certified nurse aide (CNA). Noted

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	125046	A. BUILDING _____ B. WING _____	07/28/2023

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 688	Continued From page 31	F 688		

documentation that R14 refused five out of fourteen times within the time frame. Activity was documented as done on six of the 14 times and three times were left unanswered.

2) During an observation on 07/27/23 at 10:41 AM, R16 stated to the surveyor "I need to get these fixed" while holding up both hands showing the surveyor and the nurse. Hands both look contracted. I wanted to call the doctor, but I don't have a phone and the phone out there doesn't work well. Surveyor asked nursing staff if any referrals were made to the doctor to evaluate R16's contracted hands.

On 07/27/23 at 11:07 AM, reviewed R16 EHR. MDS dated 05/29/23 was reviewed (cross reference to F641 Accuracy of Assessments).

During observations on 07/28/23 at 09:28 AM, R16 was in bed reading the paper and both hands appeared to be stiff and contracted. The resident did not have an air mattress both legs were in direct contact with the bed mattress and the resident had a dressing on the right small toes. Asked R16 if staff have been applying any type of splints or stretching exercises for both legs. R16 replied, "No".

During an interview with PT on 07/28/23 at 09:36 AM, asked the PT what type of restorative care is being done with R16. She stated that nursing is working on a referral for him to see a specialist because of his type of lower extremity contractures, his legs are straight and stiff. We are on referral to do his assessment. We tried to do the stretching with him, and he was having too much pain. We tried a bolster for his legs, but it didn't work. Nursing is working on a referral to an

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	125046	A. BUILDING _____ B. WING _____	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

(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 32 outside specialist that can provide more mechanical treatment that we can't provide here. I'm going to work with him. When asked if he is receiving restorative care for his hands? The PT stated that he was only evaluated for a built-up spoon, and it was discontinued. Surveyor requested a copy of the PT evaluation and/ or consultation report. On 07/28/23 at 10:10 AM, a request was made with the Administrator for a copy or documentation of R16's referral to a specialist to address the resident's unique type of lower extremity contractures which the facility's physical therapy staff could not properly address and/or treat. This surveyor did not receive the requested or relevant documentation. DON1 and DON2 interviewed on 07/28/23 at 11:37 AM. Surveyor asked DON1 and DON2 if they can look at the MDS for R16 and asked why the Functional status wasn't coded for the contracted BUE's. Both DONs looked in the EHR and validated that it is not coded and stated, it probably never came up, until now when he said something. Agreed that the assessment drives the care plan, so if it isn't coded, it will not be addressed, and restorative care wouldn't normally be provided.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		9/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. BUILDING _____ B. WING _____	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 695	Continued From page 33 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure professional standards of practice were implemented for a resident (Resident (R) 47) using a suction machine. As a result of this deficient practice, resident was placed at risk for potential of harm related to respiratory infection. This deficient practice has the potential to affect all residents that require suctioning. Findings Include: On 07/25/23 at 10:03 AM, observed R47 lying in his bed with his eyes closed. R47 had a suction machine on his bedside table and the suction tip wrapped in a paper towel on his bed. The cannister was filled with a frothy, clear to whitish fluid and was halfway full. Date written on the cannister was 07/09/23. Record review revealed that R47's diagnoses included lung cancer and he is taking guaifenesin (cough medicine) four times a day to help clear mucus or phlegm in his lungs. At 01:03 PM, interview conducted with R47 in his room. Observed R47 coughing and able to spit out whitish phlegm into a basin that was lined with a plastic bag. Asked resident if he also uses the suction machine. R47 said he does and proceeded to turn the suction machine on and placed the suction tip in his mouth. Noted the suction cannister was still halfway full. At 02:28 PM, asked Resident Care Manager (RCM) 1 how often the staff change the suction cannisters. RCM1 responded daily or more often if needed. Asked if the staff write the date on the cannister	F 695	1. Resident #47□s suction canister, yankauers and tubing were changed, dated, and labeled appropriately. Licensed nurses were inserviced regarding changing suctioning equipment by the DON/designee. Inservices will be ongoing as needed. 2. Residents utilizing suctioning have the potential to be affected by this alleged practice. 3. Current residents utilizing suctioning had their equipment changed and labeled appropriately. Licensed nurses were inserviced regarding changing suctioning equipment by the DON/designee. Inservices will be ongoing as needed. Policy reviewed and updated and licensed nurses were inserviced by DON/designee. 4. RCM/designess will monitor compliance with suctioning equipment through observation rounds audits weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. BUILDING _____ B. WING _____	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 695	Continued From page 34 when they change it, RCM1 said "Yes." Suction cannister that was still connected to the machine in R47's room was shown to RCM1. Cannister is now more that halfway full and dated 07/09/23. RCM1 stated, "Oh my, they should have changed it a long time ago. So sorry, I'll do it now." RCM1 removed the old suction cannister, placed it in a plastic bag and discarded it in a biohazard bin. On 07/28/23 at 08:18 AM, observed R47 was not in his room. Cannister connected to suction machine on the bedside table was halfway filled with a frothy, clear to whitish fluid. RCM1 was at the nurses' station and stated R47 just left for his eye doctor appointment. On 07/28/23 at 11:22 AM, interview conducted with the Infection Preventionist (IP). Asked IP how often do the staff change the suction cannisters. IP responded the staff change them weekly or as needed when it is halfway full. IP also said the facility did not have a written policy for changing the suction cannisters. Review of the facility policy, "Suctioning oropharyngeal - nasopharyngeal" with an effective date of 06/19/23 done. There was no mention of how often the suction cannisters should be changed. On 07/28/23 at 12:02 PM, interview conducted with Maintenance Worker (MW) 2 and Administrator in the maintenance office. Asked MW2 if he knows how often should the suction cannisters be changed. MW2 said, "We don't do that, nursing department does."	F 695		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.	F 732		9/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. BUILDING _____ B. WING _____	07/28/2023

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F 732	Continued From page 35 §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure the daily nurse staffing	F 732	1. Daily staff posting was moved to a more visible location. Staff were	

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F 732	Continued From page 36 information was in a prominent area. Finding includes: On 07/27/23 at 12:19 PM, while on Unit 1 this surveyor was unable to locate the daily nurse staffing information. At 12:20 PM, conducted an interview and observation regarding posting the daily nurse staffing information with the Director of Nursing (DON)1. The DON1 stated that the daily nursing information is written daily on the whiteboard behind the nursing station. Review of the whiteboard with the DON1 documented the role of the staff (licensed nurse or Certified Nursing Aide (CNA)) was not identified. This surveyor observed a single sheet of paper with the appropriate information, but it was difficult to distinguish it from the multiple other white papers posted on the bulletin board. The daily nurse staffing information blended in with other papers and the DON1 did not identify that it was posted, and this surveyor pointed it out. The DON1 confirmed the daily nurse staffing information was not posted in a distinguished and prominent manner and readily identifiable by residents and visitors.	F 732	inserviced regarding having the form posted in a highly visible location by the DON/designee. Inservices will be ongoing as needed. 2. Facility residents have the potential to be affected by these alleged practices 3. Staff were inserviced regarding location and visibility of posting and signage by the DON/designee. 4. RCM/DON/designee will monitor compliance with easily visible posting of staffing through observation rounds 3 x weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		9/11/23

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F 756	Continued From page 37 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure the drug regime of each resident is reviewed at least once a month by a licensed pharmacist for 1 of 6 residents (Resident (R)8) sampled. Review of R8's Electronic Health Record (EHR) documented the pharmacist did not conduct a monthly drug regime review for May 2023 and June 2023 until 07/27/23, after surveyor requested documentation of May 2023	F 756	1. Pharmacist sent resident #8 Drug Regime Review (DRR) for May and June 2023. 2. Facility residents have the potential to be affected by these alleged practices 3. DON/designee inserviced pharmacy consultant regarding timely completion of	

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F 756	Continued From page 38 and June 2023 Drug Regime Review (DRR). As a result of this deficient practice, the residents are at potential physical harm. Findings include: On 07/27/23 at 09:15 AM, conducted a review of R8's EHR. Review of the EHR documented R8 had an order for Bupropion HCl extended-release tablet 150 milligrams (mg) twice a day (BID) ordered on 04/21/23 and Sertraline 100 mg tablet, once a day was ordered on 04/21/23. This surveyor was unable to locate the DRR for R8 and requested the facility to provide the documentation. On 07/28/23 at 08:08 AM, received the requested documentation of R8's DRR. For May 2023, an observation date for May 2023 the Pharmacist Drug Regime Review was completed and the date recorded was 07/27/23 at 20:10 (08:10 PM) and June 2023 Pharmacist Regime Review was completed, and the date recorded was 07/28/23 at 02:04 AM. The Pharmacist Drug Regime Review was completed after this surveyor requested the documents. On 07/28/23 at 11:28 AM, conducted a telephone interview with the Pharmacist (P)1 that completed R8's DRR. Inquired with P1 about the completion of R8's DRR, why the DRR was completed on the observations list and not on the usual pharmacy form. P1 stated the observation form of the DRR id a back-up, a secondary form for the pharmacy's form. P1 stated there was a delay in the documentation of R8's DRR due to technical, internet connectivity issues. P1 stated the pharmacy's process is to email the DRR recommendations to the DON1 then go into the	F 756	DRR. DON/designee will review the pharmacy DRR monthly report to ensure accurate capture of current resident census. Any discrepancies will be brought to pharmacy consultant attention for completion. 4.DON/designee will monitor pharmacy consultant DRR through monthly medical record review for a minimum of 3 months or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved.	

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F 756	Continued From page 39 resident's EHR and document the recommendations in observations. P1 reviewed his/her emails to the facility and stated May 2023 DRR was emailed on 06/13/23 and June 2023 DRR was emailed on 07/17/23 and recommendations for R8's DRR was included in the email. On 07/28/23 at 11:43 AM, conducted a concurrent interview and record review of R8's EHR with the DON1. DON1 reviewed R8's EHR and confirmed the May 2023 and June 2023 DRR was not completed monthly and was completed after the documents were requested by this surveyor. The DON1 reviewed emails from P1 regarding the pharmacist monthly DRR for May 2023 and June 2023. The DON1 received the emails as stated by P1. Requested to review the email for documentation of P1's review of R8's DRR for May and June 2023. DON1 reviewed P1's DRR emails and confirmed R8's monthly DRR was not included in the emails.	F 756		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		9/11/23

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F 761	Continued From page 40 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to appropriately address out of range temperature for one of its two medication refrigerators and discard expired glucose testing supplies. This deficient practice has the potential to negatively affect the efficacy and integrity of medications that require to be stored at proper temperatures and placed all residents that need glucose testing at risk for potential harm as their medical care is dependent on precise glucose test results. Findings Include: On 07/28/23 at 09:07 AM, observation of the medication refrigerator was done with Resident Care Manager (RCM) 1 in the medication storage room. The refrigerator contained insulin, suppositories, and vaccines. A document titled "Medication Refrigerator Temperature Record" was placed in a plastic protective sleeve on the door of the refrigerator. RCM1 said the nurses check and log the temperature daily. Review of the document showed that under "Standard", the temperature range was noted as 36-46 degrees	F 761	1. The expired control solution was disposed of and replaced. The medication refrigerator functioning was checked, and the thermometer was replaced. 2. Facility residents have the potential to be affected by these alleged practices 3. DON/designee inserviced licensed nurses regarding checking expiration dates on medications and solutions, normal refrigerator temperature parameters, daily checking of refrigeration temperatures and notifying maintenance or Administrator of abnormal refrigerator temperatures. Inservices will be ongoing as needed. 4. RCM/designee will monitor compliance regarding expired medication/solutions/refrigerator temperatures through observation rounds of med carts and rooms weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI	

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F 761	Continued From page 41 Fahrenheit (F). Temperature was noted to be out of range on the following days: 07/21/23- 48 degrees F; 07/22/23- 47 degrees F; 07/23/23- 48 degrees F; and 07/26/23- 47 degrees F. Asked RCM1 if the out-of-range temperature readings were addressed according to the "Medication Refrigerator Temperature Record", he responded "No." On 07/28/23 at 12:12 PM, concurrent interview and record review conducted with the Administrator in her office. Showed Administrator a copy of the "Medication Refrigerator Temperature Record" from Unit 2 and asked what the staff should have done with the out-of-range temperature readings. Administrator responded, "The staff should have followed the steps on the temperature log. They should have rechecked the temperature and if it was still out of range, report it to the maintenance staff so they can adjust the setting for the refrigerator." On 07/28/23 at 09:20 AM, observation of the medication cart was done with RCM1. An open box of Assure Dose Control Solution was found next to the blood glucose meter in the top drawer of the cart. Date written on the box and its contents was 03/23/23. Asked RCM1 if that was the date the box was opened, he said "Yes." Asked RCM1 if that is the control solution the staff use when checking if the blood glucose meter was working properly, he said "Yes." When RCM1 was asked how long the control solution was good for after opening, he said it was only good for 90 days. RCM1 apologized and added he will discard it and get a new set. Manufacturer note on the side of the box stated, "Important: ... Use within 90 days after first opening." RCM1 also said that there were six residents in the unit	F 761	for review and recommendation for a minimum of 3 months or until compliance is achieved.	

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F 761	Continued From page 42 that have their blood glucose checked daily.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to follow food safety requirements. The temperature for the refrigerator used for food storage was out of range and a container of juice was found in a refreshment refrigerator that was over one month from the date it was opened. This deficient practice has the potential to affect all residents, visitors and staff who have meals served by the facility, placing them at risk for food-borne illnesses. Findings include:	F 812	1. Auxiliary kitchen refrigerator door was checked to ensure proper functioning. RD checked and food/liquid temperatures were within parameters. Expired liquid was disposed of from the nourishment refrigerator. Nourishment refrigerators were audited for expired food/liquids and cleaned out as needed. Resident #34 was not identified on the resident list provided by OHCA thus no follow up could be completed. 2. Facility residents have the potential to	9/11/23

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F 812	Continued From page 43 On 07/27/23 at 10:32 AM while checking on the nourishment refrigerator in Unit 2, an opened container of prune juice was found that was half full. The date written on the cap was 06/14/23. Asked Registered Nurse (RN) 18 how long the container of prune juice is good for once opened. RN18 said she was not sure but will ask kitchen staff. RN18 then called the kitchen and spoke to one of the staff. After RN18 hung up the phone, she confirmed the prune juice was only good for 7 days after it has been opened. RN18 apologized and proceeded to empty the bottle in the sink. Asked RN18 if there were any residents that received prune juice for the month of July 2023. RN18 said she was not sure and would have to check the medication administration records (MAR). Review of the MARs for the unit revealed that Resident (R) 34 was given prune juice on 07/14/23 and 07/26/23. RN18 confirmed that the prune juice given to R34 was from the same bottle that was in the refrigerator. No other containers of prune juice were found in the nourishment refrigerator. 2) During a brief tour of the kitchen on 07/25/23 at 09:00 AM, in the annex kitchen, noted the refrigerator right side door was open approximately five inches. The internal temperature gauge and outer digital temperature read 55 degrees Fahrenheit (F). Inside were bananas, sandwiches and milk containers with condensation on the surfaces. Notified the kitchen supervisor that the refrigerator door was left open and that the temperature reading was 55 degrees F.	F 812	be affected by these alleged practices 3. The Food Service Supervisor inserviced the dietary staff regarding proper closure of refrigerator door to ensure maintaining appropriate temperature parameters. Inservices will be ongoing as needed. DON/designee inserviced the staff regarding expiration dates of opened items and guidelines for discarding. Inservices will be ongoing as needed. 4. Food Service Supervisor/designee will monitor compliance through observation rounds 3 x weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved. RCM/designee will monitor compliance with the nourishment refrigerators through observation rounds audits weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		9/11/23

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F 883	Continued From page 44 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 883		

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F 883	Continued From page 45 already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure one of five residents (Resident (R) 47) sampled for immunization was provided the influenza vaccine. This deficient practice placed the resident at risk of acquiring, transmitting or experiencing complications from seasonal influenza. Findings Include: Review of Electronic Health Records (EHR) revealed that R47 is a 76-year-old resident admitted on 02/02/23 as a lateral transfer from another long term care facility. Diagnoses include diabetes (high blood sugar levels) and lung cancer. Immunization records from previous facility showed his last influenza vaccine was administered on 12/16/20. Review of scanned documents under "Consent Forms" revealed that R47 signed a consent to receive the influenza vaccine on 02/02/23, however, there was no record in the EHR showing the vaccine was administered.	F 883	1. Resident #47 will receive annual flu vaccination per signed consent for upcoming flu season per his request. DON/designee inserviced licensed nurse regarding inputting and follow up on orders. Inservices will be ongoing as needed. 2. Residents requesting flu vaccinations have the potential to be affected by this deficit practice. 3. RCM/designee audited current residents for compliance with flu vaccination and follow up occurred as needed. New residents will be reviewed in WAR for vaccination status and follow up will occur as needed. DON/designee inserviced licensed nursing staff regarding inputting and following up on physician orders re: flu vaccinations. Inservices will be ongoing as needed.	

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

(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 883	Continued From page 46 On 07/28/23 at 01:45 PM, concurrent interview and record review was conducted with Director of Nursing (DON) in his office. Asked DON if there is another place in the EHR where the nurses would document administration of the influenza vaccine. DON said, "The nurses would sign it off in the MAR (medication administration record) and document it in the "Preventive Health" tab." Survey team was not given access to the "Preventive Health" tab. Asked DON if he can show where the administration of the influenza vaccine was documented in the "Preventive Health" tab, but he was not able to. DON said he will keep looking and let the survey team know when he has located it. DON also showed that there was an order entered on 02/02/23 for the vaccine to be given. No documentation of the administration of the influenza vaccine was provided to the survey team by the time of the exit conference.	F 883	4. RCM/designee will monitor compliance with flu vaccinations through medical record audits weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved.	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide an adequate call system so the resident could communicate with the nursing	F 919	1. RCM/designee instructed resident #36 on how to use the call pad and was able to perform a return demonstration. The	9/11/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. BUILDING _____ B. WING _____	07/28/2023

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PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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F 919	Continued From page 47 staff. The deficient practice places the resident at an increased risk of harm. One Resident (R)36 had a touch pad call light that was placed out of reach. Resident was not able to demonstrate how to use it to call the nurse. Findings include: During an observation on 07/26/23 at 09:38 AM noted the touch pad (call light) for R36 was found on the upper left corner of the mattress out of his reach. Asked the resident if he knew how to call for help? He shook his head no. Surveyor tested the touch pad, and the call light came on. R36 stated "I never knew that's how to call for help". A certified nurse aide (CNA) came in to answer the call light and the resident said he wanted something to eat. Surveyor asked the CNA if he knows how to use the call light. The CNA said that he should, but the aide probably forgot to put it back after she repositioned him.	F 919	call pad is being placed so that the resident can easily access it as needed. 2. Residents needing to use pad call lights have the potential to be affected by this alleged practice. 3. DON/designee inserviced staff on proper placement and to instruct residents on how to use call pad. RCM/designee assessed those residents with call pads and their ability to use them and educated as needed. Inservices/education will be ongoing as needed. 4. RCM/designee will monitor compliance with call pad placement and resident□s ability to use by observation round audits weekly for a minimum of 12 weeks or until compliance is achieved. Results will be taken to QAPI for review and recommendation for a minimum of 3 months or until compliance is achieved.	