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	125056	A. BUILDING _____ B. WING _____	05/03/2024

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HALE MAKUA HEALTH SERVICES	1540 LOWER MAIN STREET WAILUKU, HI 96793

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 04/30/24 - 05/03/24. The facility was found not to be in substantial compliance with 42 CFR §483, Subpart B. Survey Dates: 04/30/24 - 05/03/24 Survey Census: 79	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on an interview with one Resident (R)42 of seven residents sampled, the facility failed to provide reasonable accommodations related to R42's showering and meals. As a result of this deficiency, there was risk for decline of R42's maintenance of independent functioning, dignity and well-being. Findings include: During resident interview on 05/02/24 at 09:30AM, R42 stated when facility staffing was short, it would take around thirty minutes to an hour for staff to respond to his call light. R42 said he needed assistance reaching for the soap when taking a shower. Also, it would take longer (around forty-five minutes) for staff to deliver	F 558	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal law. F558 1. The Administrator met with resident# 42 to review his concerns. Resident denies any issues at present. The Administrator will continue to meet with the resident on a regular basis to review progress on his	6/12/24

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

Electronically Signed | 05/20/2024

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F 558	Continued From page 1 meals to resident's rooms when short staffed. Review of Electronic Health Record showed that R42 was admitted on 05/17/22 with diagnoses including Respiratory Failure, Chronic Obstructive Pulmonary Disease, Pulmonary Edema, Congestive Heart Failure, Atrial Fibrillation, Pulmonary Arterial Hypertension, Atherosclerotic Heart Disease, Cardiomegaly, Abdominal Aortic Aneurysm, High Cholesterol.	F 558	concerns. Nursing staff were in-serviced regarding having needed equipment such as soap within easy reach of resident. 2. Facility residents have the potential to be affected by these alleged practices. 3. A call light audit was completed and found to have response times to be under 5 minutes. Meal delivery was audited and found to be less than 10 minutes from the start to finish to deliver resident meals. The facility non-nursing and nursing staff were in-serviced regarding timely answering of call lights by the Administrator/DON/SDC/Designees. The nursing staff were in-serviced regarding timeliness of meal delivery and assistance for showers by DON/SDC/Designees. In-services will be ongoing as needed. 4. The administrator/DON/designees will monitor call light response and meal delivery times through weekly observations and resident interview audits for a minimum of 12 weeks or until substantial compliance is achieved. The DON/designees will monitor bathing/showering assistance through weekly observations and resident interview audits for a minimum of 12 weeks or until substantial compliance is achieved. The Administrator and DON will bring the results of these audits to the monthly QAPI meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	

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F 684	Continued From page 2	F 684		
F 684 SS=D	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 interview and record review, the facility failed to appropriately perform diabetes management for 1 of 18 residents (Resident 22) in the sample by failing to ensure his blood sugars were measured, and his sliding scale insulin was administered at the appropriate times. As a result of this deficient practice, Resident (R)22 was placed at risk for an avoidable decline and/or injury related to his diabetes. This deficient practice has the potential to affect all the residents at the facility with insulin-dependent diabetes. Findings include: 1) Resident (R)22 is a 75-year-old male admitted on 03/08/23 with diagnoses that include spondylosis, lumbosacral region (age-related change of the bones (vertebrae) and discs of the lower spine, causing pain), fusion of spine, thoracic region (a surgical procedure in which two or more bones (vertebrae) of the upper and middle part of the back are joined together), osteoarthritis, right shoulder (the wearing down of the protective tissue at the ends of bones),	F 684	F684 1. Resident #22's physician was notified of the late administration of insulin. The physician reviewed the resident's current condition and plan of care. The plan of care was updated as needed. The nurses involved with Resident #22 were in-serviced by the Unit Managers during survey regarding blood sugar testing and the appropriate administration of insulin. 2. Facility residents, who are insulin dependent diabetics, have the potential to be affected by the alleged practices. 3. Current insulin dependent residents were reviewed for compliance. No issues were found. Licensed nurses were in-serviced by the DON/UM regarding blood sugar testing and the appropriate administration of insulin. In-services will be ongoing as needed. 4. The DON/UM/designees will monitor compliance through observation rounds	6/12/24

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F 684	Continued From page 3	F 684		

chronic pain, and diabetes with long-term use of insulin.

On 05/01/24 at 08:51 AM, an interview was done with R22 at his bedside. When asked about his blood sugar checks and his sliding scale insulin, R22 reported that sometimes the nurses check his blood sugar and give him his sliding scale insulin after he has already begun eating his meal, or even after he has completed it. When R22 has commented on it, the nurses have told him, "We have a one-hour grace period."

A review of R22's provider orders noted an order for Insulin Lispro sliding scale (dosage is titrated based on blood sugar result) "before meals," scheduled for 06:00 AM, 11:00 AM, and 04:00 PM, and started on 03/15/24. From 02/22/24 to 03/15/24, there was an order for Insulin Aspart sliding scale before meals, also scheduled for 06:00 AM, 11:00 AM, and 04:00 PM.

A review of R22's Medication Administration Record (MAR) for March 2024 noted that the sliding scale insulin was documented as "Late Administration: Charted Late [reflecting it was given more than one hour after it was due]" 20 times. A review of R22's MAR for April 2024 noted late administration of his sliding scale insulin documented 11 times.

On 05/03/24 at 09:36 AM, an interview was done with the Director of Nursing (DON) and the Administrative Nurse/Charge Nurse (CN)3 in the DON office. Both the DON and CN3 confirmed that sliding scale insulin should be administered immediately after the blood sugar is taken, and documented on the MAR immediately after it is given. They also agreed that since the insulin

and medical record reviews weekly of residents receiving insulin that it is administered timely for a minimum of 12 weeks or until substantial compliance is achieved. The DON will bring the results of these audits to the monthly QAPI meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.

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F 684	Continued From page 4 dose is dependent on the blood sugar result, which would be altered with food consumption, it is crucial that it is done before the resident begins eating to decrease the risk of a hypoglycemic (low blood sugar) episode. As a result, the DON and CN3 confirmed that there is no "grace period" for sliding scale insulin and late administration(s) should not be happening. Upon concurrent review of the late administrations documented on the MARs with CN3, she expressed surprise that there were so many and explained that the Unit Managers should be monitoring that daily. Review of Treatment of Type 2 Diabetes Mellitus in the Older Patient, last updated on 01/04/24, and found at https://sso.uptodate.com/contents/treatment-of-type-2-diabetes-mellitus-in-the-older-patient?search=slding%20scal%20insulin%20in%20an%20older%20adult&sectionRank=1&usage_type=default&anchor=H33&source=machineLearning&selectedTitle=1%7E150&display_rank=1#H4 noted the following: "Hypoglycemia should be avoided in older adults ... Even a mild episode of hypoglycemia may lead to acute, adverse outcomes in frail older patients, including falls and fractures."	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		6/12/24

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F 689	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 2 of 7 residents (Residents 62 and 29) sampled were free from accident hazards. The facility failed to develop effective interventions to prevent avoidable falls for Resident (R)62, and R29 was transferred from his bed to a shower chair using a mechanical lift device he had not been evaluated as safe to use. Placing residents at risk of avoidable accidents and injuries by not providing the appropriate assessments, planning, monitoring, and recommendations, and/or implementing the appropriate interventions is a deficient practice that has the potential to affect all the residents at the facility. Findings include: 1) R62 is a 32-year-old resident admitted to the facility on 02/29/24. Diagnoses include but are not limited to traumatic brain injury following a motor vehicular accident; fractures to base of skull, maxilla (upper jawbone), orbit (eye socket), nasal bones, right clavicle (collar bone), and left carpal bone (wrist); and acute respiratory failure. On 04/30/24 at 12:50 PM, observed R62 lying supine in bed with his eyes closed. Height of bed was at the lowest setting and there was a fall mat on the right side of the bed. Review of R62's Electronic Health Record (EHR) conducted. Fall risk assessment was completed on 02/29/24 and R62 had a score of 10 indicating he is at a moderate fall risk. After his first fall on 03/08/24, another fall risk assessment was done and score increased to 17 indicating a high fall	F 689	F689 1. Resident #62 has been discharged. Resident #29 was re-evaluated by therapy for appropriate transfer methods and the use of the Sera lift sit to stand was discontinued for this resident. The nursing staff involved were in-serviced regarding implementing and reassessing fall interventions and the appropriate use of the Sera lift by the UM/Designee. 2. Facility residents have the potential to be affected by the alleged practices. 3. Residents currently using the Sera lift were re-evaluated by therapy for appropriateness. Facility nursing staff were in-serviced regarding falls, implementing and reassessing interventions, and appropriate use of the Sera lift by the UM/designees. In-services will be ongoing as needed. 4. The DON/UM/designees will monitor compliance through observation rounds and medical record reviews weekly for a minimum of 12 weeks or until substantial compliance is achieved. The DON will bring the results of these audits to the monthly QAPI meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	

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risk. The most recent fall risk assessment was done on 04/26/24 with a score of 25 indicating a high fall risk. Care plan interventions included offering snacks and activities, use of pommel cushion while on wheelchair to prevent sliding, frequent reminders to not attempt to stand up from wheelchair alone, use of a tab alarm, provide assistance with toileting, provide physical therapy as ordered, use padded fall mats around bed, increased staff supervision, setting bed at lowest position with wheels locked, and medication review to assess for medications that increase the risk of falls. Care plan also documented that the resident prefers not to use side rails while in bed and refused to use a helmet as recommended by the physician. Progress notes revealed that R62 had falls on the following dates:

03/08/24 at 10:30 AM, found on the floor in his room.
03/14/24 at 08:00 AM, found kneeling on the floor in his room after hearing tab alarm.
03/20/24 at 04:05 PM, staff witnessed R62 fall to the floor in front of the nurses' station while trying to stand up from wheelchair.
03/21/24 at 08:50 AM, found sitting on the floor in his room while responding to tab alarm.
03/23/24 at 09:55 AM, staff witnessed R62 fall to the floor in front of the Activities Department walkway while trying to stand up from wheelchair.
03/29/24 at 07:55 AM, staff witnessed R62 fall to the floor in front of the nurses' station while trying to stand up from wheelchair.
03/30/24 at 05:25 AM, found sitting on the floor in his room while responding to tab alarm.
04/02/24 at 07:15 AM, staff witnessed R62 trying to get up from the wheelchair and fell hitting his face on the frame of the door. Wheelchair was

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parked in front of the nurses' station.
04/20/24 at 11:00 AM, staff witnessed R62 fall to the floor in the common area near the nurses' station trying to stand up from wheelchair.
04/24/24 at 03:50 PM, staff witnessed R62 fall on the floor at the TV area in front of the nurses' station while trying to stand up from the wheelchair by pulling himself up using the railings.
04/26/24 at 11:15 AM, found sitting on the floor next to his wheelchair at the table area near the nurses' station.

On 05/03/24 at 09:27 AM, an interview was conducted with Charge Nurse (CN) 1 at the nurses' station. Asked CN1 how often do the staff check on R62. CN1 said staff check on R62 every hour and document it on the log that is kept in the nurses' station. Reviewed log with CN1, hourly checks were initiated on 03/08/24 after the first fall. When asked if the hourly checks were effective given that R62 has had 10 more falls since it was implemented, CN1 said "I think it is working, the falls happen on various times." CN1 also stated that the facility provides a "sitter" when R62 becomes restless, was prescribed an antianxiety medication on 03/28/24 to help him calm down and started on physical therapy on 03/13/24 to strengthen his legs.

On 05/03/24 at 10:05 AM, an interview was conducted with the Director of Nursing (DON) by the Lanai wing nurses' station. Asked DON if the hourly checks are enough to prevent more falls for R62. DON said the facility is not able to provide one-on-one supervision for any residents 24 hours a day. DON also stated that they hired extra clerical staff that help monitor R62 in the afternoon and therapy was started to strengthen

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his legs to prevent him from falling when he attempts to stand up from the wheelchair. DON added that the facility does not want to implement the use of restraints on R62.

2) Resident (R)29 is an 85-year-old male admitted to the facility on 10/16/18 for long-term care following a stroke. A review of R29's Minimum Data Set (MDS) quarterly assessment with an assessment reference date (ARD) of 04/03/24, Section GG-Functional Abilities and Goals, noted that R29 is completely dependent on staff for all Activities of Daily Living (ADLs) such as eating, toileting, dressing, and bathing, as well as all mobility activities such as rolling from side to side in bed, sitting up in bed, and transferring in and out of bed. Of note is that on the last three MDS assessments documented, no weight-bearing activities were evaluated, and instead were documented as "Not attempted due to medical condition or safety concerns."

On 05/02/24 at 02:29 PM, observed Certified Nurse Aide (CNA)24 and CNA3 preparing to use a mechanical lift to transfer R29 from his bed to a shower chair. The mechanical lift used for the transfer was one that lifts the resident from the seated position at the edge of the bed to a standing position on the lift itself. Observed that R29 was unable to sit up or remain in the seated position at the edge of the bed on his own. CNA24 and CNA3 had difficulty manually lifting R29 to the seated position and holding him there as the lift harness was applied. R29 fell back onto the bed in a semi-reclined position at one point and had to be manually lifted to a seated position a second time. Observed CNA24 lift both R29's feet up and place them on the lift platform without

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his assistance. Then observed CNA24 lift R29's right hand and place it on the right handle of the lift. CNA24 was able to grip the handle once his hand was placed there. CNA3 then lifted R29's left hand to do the same on the left handle, however she had to open R29's left hand, place it on the handle, and manually close his fingers around the handle. R29 was unable to tighten his grip onto the left handle as he had done on the right. At no point during the transfer were the wheels on the mechanical lift placed in a locked position. When asked if the lift wheels should be locked for safety, CNA3 responded that they should have locked the wheels before lifting R29 from the seated position to standing.

A review of the User Instruction Manual for the mechanical lift used revealed the following:

"The ... [mechanical lift] is suitable for patients in the SITTING position only who have a degree of weight-bearing ability but require assistance to stand."

A review of R29's comprehensive care plan for ADLs revealed no determination of weight-bearing ability, but does note the following:

"I [R29] am dependent on staff for all my ADLs."

"I [R29] am non-ambulatory."

A review of the last Physical Therapy PT Evaluation & Plan of Treatment, dated 09/06/22, revealed that R29 had been referred for "transfer and strength training." The therapist documented that he was unable to complete an assessment of R29's level of function due to his refusal to participate. Further review of the document notes

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that no plan of treatment had been developed, and no recommendations were made.

On 05/03/24 at 08:55 AM, an interview was done with the Director of Rehab [rehabilitation] (DOR) in the Therapy Gym. DOR confirmed that she could not find a Physical Therapy Evaluation since 2022. Upon concurrent review of the 2022 Physical Therapy Evaluation, DOR agreed that she would expect to see recommendations made, especially if unable to complete an assessment, "probably the highest safety recommendations." DOR stated that although she is not a Physical Therapist (PT) so she cannot speak for the PT that performed the 2022 evaluation, when she does an evaluation of her own as an Occupational Therapist (OT) or as the DOR, she would first ask the nursing staff what they are doing, then she would watch a transfer, and make recommendations based on that. If she were unable to do that (speak to nursing staff and watch a transfer), she would most likely recommend using the maximum level of safety for all transfers, meaning a mechanical lift used for fully dependent residents who are unable to participate or help in the transfer.

Since the PT who conducted the 2022 evaluation was unavailable for interview, on 05/03/24 at 09:05 AM, a phone interview was done with PT5, who stated he was not familiar with R29. When asked what he would look for when assessing a resident for functional ability/mobility specifically to make a recommendation regarding the mechanical lift used with R29, PT5 responded that he would want to ensure the resident was able to place their feet on the floor/lift device, able to extend their knees, able to hold themselves up in a seated position, and able to tighten their

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F 689	Continued From page 11 grasp on the lift handles on both sides. On 05/03/24 at 09:08 AM, further questioning was done of DOR, who stated she was familiar with R29's occupational therapy function. DOR confirmed that R29 would not be able to tighten his grasp on the lift handle on the left side due to contractures in his left hand.	F 689		
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 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, staff interview and review of policy, the facility failed to label the humidified sterile water bottle for one Resident (R)177 of five residents sampled. As a result of this deficiency, the facility put R177 at increase risk for sterile water contamination. Findings include: During observation of R177's oxygen delivery set up on 05/01/24 at 08:30 AM, the humidified Sterile Water Bottle was not labeled with the date and time opened. Staff interview on 05/01/24 at 08:40 AM, Charge Nurse (CN)2 acknowledged that the Sterile Water	F 695	F695 1. Resident #177 has been discharged. During the survey, the resident's humidifier bottle was replaced and labeled appropriately. 2. Facility residents, on oxygen using humidifier bottles, have the potential to be affected by the alleged practices. 3. Residents on oxygen with humidifier bottles were audited to ensure they were labeled appropriately by the UM/designee. Licensed nurses were in-serviced regarding appropriate labeling of oxygen equipment policy re: humidifier bottles by	6/12/24

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F 695	Continued From page 12 Bottle should have been labeled with the date and time opened and initials. CN2 subsequently replaced the oxygen delivery/sterile water bottle with new equipment. Review of facility policy on Oxygen Administration read Purpose; To deliver oxygen to the guest/resident when insufficient oxygen is being carried by the blood to the tissues. Procedure ... c. Attach humidifier to flowmeter by screwing nut onto the flow meter if needed. If the humidifier has an audible alarm, check this by adjusting the flow rate and pinching the tubing until the alarm sounds ... g. Label humidifier with date and time opened and your initials ...	F 695	the UM/designee. In-services will be ongoing as needed. 4. The DON/UM/designees will monitor compliance through observation rounds of residents receiving humidified oxygenation to ensure properly labeled weekly for a minimum of 12 weeks or until substantial compliance is achieved. The DON will bring the results of these audits to the monthly QAPI meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to manage pain adequately for 1 of 4 residents (Resident 22) sampled for pain. Specifically, the facility failed to ensure that Resident (R)22's pain regimen was implemented on a timely basis. As a result of this deficient practice, R22 was prevented from attaining or maintaining his highest practicable level of well-being. Findings include:	F 697	F697 1. Resident #22's pain levels and pain medications are being monitored and documented every shift and the resident's Care Plan was updated to reflect his wishes concerning administration of his pain medications. The licensed nurses involved were in-serviced regarding the appropriate timely administration of pain medications by the UM/Designees. 2. Facility residents receiving pain	6/12/24

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F 697	Continued From page 13 Resident (R)22 is a 75-year-old male admitted on 03/08/23 with diagnoses that include but are not limited to, spondylosis, lumbosacral region (age-related change of the bones (vertebrae) and discs of the lower spine, causing pain), fusion of spine, thoracic region (a surgical procedure in which two or more bones (vertebrae) of the upper and middle part of the back are joined together), osteoarthritis, right shoulder (the wearing down of the protective tissue at the ends of bones), and chronic pain. On 05/01/24 at 08:55 AM, an interview was done with R22 at his bedside. R22 was sitting up in bed with a stiff posture, leaning awkwardly to the right, and appeared as if he did not want to move his head. When asked about pain, R22 stated "I'm always in pain, it's so hard to get my pain managed. When they [nursing staff] constantly late [with his routine/scheduled pain medication] that's when I get upset." R22 complained that between 03:00 PM and 11:00 PM especially, his routine/scheduled pain medications are "always late." When he complains to the nurses about his medication being late, he is told "we have a 1-hour grace period." R22 rated his current pain level as a 7 out of 10, located to his neck and lower back. R22 repeated, "I cannot handle when the meds [medications] come late." A review of R22's provider orders noted the following orders for routine/scheduled pain medications: Acetaminophen 1000 milligrams (mg) three times a day, scheduled for 08:00 AM, 02:00 PM, and 08:00 PM. Baclofen 10mg three times a day, scheduled for	F 697	medications have the potential to be affected by the alleged practices. 3. Current residents receiving pain medications were audited to ensure compliance of timeliness. Licensed nursing staff were in-serviced regarding the appropriate timely administration of pain medication by the UM/designees. In-services will be ongoing as needed. 4. UM/designees will monitor compliance through medical record reviews of medication administration times for residents receiving routine pain medication and resident interviews weekly for a minimum of 12 weeks or until substantial compliance is achieved. The DON will bring the results of these audits to the monthly QAPI meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	

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08:00 AM, 02:00 PM, and 08:00 PM.

Gabapentin 400mg (increased to 600mg on 04/25/24) three times a day, scheduled for 08:00 AM, 02:00 PM, and 08:00 PM.

Marinol 10mg twice a day, scheduled for 08:00 AM and 04:00 PM.

Oxycodone 20mg routine every six hours, scheduled for 08:00 AM, 02:00 PM, 08:00 PM, and 02:00 AM.

A review of R22's Medication Administration Record (MAR) for March 2024 revealed the following:

Acetaminophen documented as "Late Administration: Charted Late [reflecting it was given more than one hour after it was due]" 6 times.

Baclofen and Gabapentin documented as given late 7 times.

Marinol documented as given late 9 times.

Oxycodone documented as given late 10 times.

A review of R22's MAR for April 2024 revealed the following:

Acetaminophen, Baclofen, and Gabapentin documented as given late 13 times.

Marinol documented as given late 6 times.

Oxycodone documented as given late 20 times. 4 of those times, the reason was documented as

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F 697	Continued From page 15 R22 was sleeping at the scheduled time, and the medication was documented as given between 1 hour, 21 minutes to 3 hours, 16 minutes late. On 05/01/24 at 10:17 AM, a follow-up interview was done with R22 at his bedside. When told that it was noted that his scheduled pain medications were sometimes documented as given late due to the resident sleeping, R22 became visibly upset and stated that he has told staff numerous times that he wants to be woken up to take his routine pain medication around-the-clock so that he can keep his pain at a tolerable level. "That shouldn't matter if I am sleeping, they should still wake me up and give it to me!" On 05/03/24 at 09:36 AM, an interview was done with the Director of Nursing (DON) and the Administrative Nurse/Charge Nurse (CN)3 in the DON office. Both the DON and CN3 agreed that every effort should be made to give scheduled pain medication on time and confirmed that all nurses should be documenting the administration of any medication on the MAR immediately after giving it. If the medication is a controlled substance (e.g., Marinol and Oxycodone), all nurses should be signing it out on the narcotic log, giving it immediately, then documenting it on the MAR as administered immediately after that. Surveyor confirmed with both that if a medication is documented as "Late Administration," it means it was given an hour or more after it was scheduled.	F 697		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	F 755		6/12/24

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F 755	Continued From page 16 drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure pharmacy services included an effective process to provide routine drugs to meet the needs of the residents, and failed to dispose of medications past their expiration date. As a result of this deficient practice, 2 residents (Residents 33 and 14) had routine medications that were out of stock, and	F 755	F755 1. Residents #14 and #33 received the missing medications. The expired IV fluids were destroyed. The nurses involved were in-serviced regarding the process to follow if a medication is missing/unavailable by the UM/designees.	

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F 755	Continued From page 17 residents who needed intravenous fluid were placed at risk of receiving expired fluids. This deficient practice has the potential to affect any patient taking medication. Findings include: 1) On 05/02/24 at 08:43 AM, while observing medication pass with Registered Nurse (RN)8, it was noted that the Losartan (a medication for high blood pressure) 100 milligrams due at 09:00 AM for Resident (R)14 was out of stock. RN8 stated he would check the emergency kit (E-kit) for it. On 05/02/24 at 09:08 AM, RN8 confirmed that there was no Losartan in the E-kit. RN8 called the pharmacy to check on when it would be delivered and stated he would also call the doctor to inform him the medication was out of stock. RN8 explained that he ordered the medication refill on 05/01/24, but he also gave the last dose in the blister pack then. RN8 confirmed that it should have been ordered before it got down to the last dose. On 05/02/24 at 09:37 AM, an interview was done with Unit Manager/Charge Nurse (CN)1 at the nurses' station. CN1 stated that the expectation is when starting the last row of medications in the blister pack (meaning 7 days left of medications), nurses should start re-ordering the medication either through the electronic health record (EHR)/pharmacy interface or by faxing the refill sticker from the blister pack to the pharmacy. CN1 confirmed that since there is only one refill sticker per blister pack, the refill sticker method can only be done once.	F 755	2. Facility residents receiving medications have the potential to be affected by the alleged practices. 3. The DON in-serviced the unit managers(UM) regarding weekly medication room/storage inspections and disposing of expired medications. Licensed nurses were in-serviced regarding the process for ordering/re-ordering of medications timely according to facility policy and the process to follow if a medication is missing/unavailable. Licensed nurses were also in-serviced regarding medication room/storage inspections and disposing of expired medications by the UM/designees. In-services will be ongoing as needed. 4. UM/designees will monitor compliance through medical record reviews and med room/storage observation rounds weekly for a minimum of 12 weeks or until substantial compliance is achieved. The DON will bring the results of these audits to the monthly QAPI meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	

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On 05/02/24 at 10:14 AM, CN1 provided documentation that the refill sticker for the Losartan was faxed to the pharmacy on 05/01/24. CN1 confirmed that it appeared that the re-ordering process was not followed which led to the medication now being out of stock.

Review of R14's EHR revealed that on 05/02/24 at 09:46 AM, RN8 documented the Losartan due at 09:00 AM as "Not Administered: Drug/Item Unavailable." At 09:50 AM, RN8 entered a one-time order from the provider to administer the Losartan at 01:00 PM. A second order was entered changing the scheduled time due to 02:00 PM, and the medication was administered successfully between 02:00 PM and 03:00 PM.

2) On 04/30/24 at 11:48 AM, observed R33 lying in bed with head elevated. When asked how she was doing, R33 complained of back pain. Asked R33 if she takes medication for the pain. R33 said she did not get any pain medications yet and asked for the nurse. Notified Charge Nurse (CN) 1 of R33's complaint of back pain. CN1 said R33 has a routine pain medication scheduled and will administer it.

Review of R33's Electronic Health Record (EHR) conducted. R33 is a 70-year-old resident admitted to the facility on 05/02/19. Orders for pain medication were Gabapentin 300 mg (milligrams) at bedtime for low back pain, Morphine 2 mg every 4 hours PRN (as needed) for pain 8-10/10, and Tramadol 50 mg twice a day and every 4 hours PRN for pain. Documented under "Progress Notes" on 04/30/24 at 01:48 PM, "Called pharmacy re: (regarding) gabapentin refill. Per pharmacy tech, this is being process [sic] for evening delivery." Another note was entered on

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05/01/24 at 09:46 AM stated. "Gabapentin was not delivered. LN (licensed nurse) again called pharmacy . . ."

On 05/03/24 at 09:48 AM, concurrent interview and record review conducted with CN1 at the nurses' station. Asked CN1 if the Gabapentin for R33 was delivered in time for her evening dose. CN1 checked the Medication Administration Record (MAR) to see if it was administered. A note on the MAR entered for 04/30/24 at 06:00 PM stated, "Not Administered: Drug/Item Unavailable. . ." Asked CN1 how early does the staff reorder routine medications. CN1 said they reorder seven days prior to the last available dose. Asked CN1 why R33's Gabapentin was not available if it was reordered 7 days prior to the last dose. CN1 said she will check the delivery records to see if it was delivered. After looking at the list of medications delivered on 04/26/24, CN1 said that Gabapentin for R33 was not included on the list for that day. CN1 also showed another document titled "pending Orders Report" from the contracted pharmacy stating Gabapentin was last filled on 04/26/24 with a handwritten note stating, "need signed receipt by nurse that it was received on 4/26/24." CN1 said that the nurse that received the medications delivered checked what was physically delivered against what is listed on the delivery record to make sure it matches. Delivered medications are not checked against a list of what was ordered so they are not able to tell if an ordered medication was missing. CN1 added that the Gabapentin for R33 was delivered on 05/01/24 so the resident only missed one dose and the attending physician was notified.

3) On 05/02/24 at 08:57 AM, inspection of the medication storage room was conducted with

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F 755	Continued From page 20 CN1. Five one-liter bags of 0.9% Sodium Chloride solution were found in one of the storage cabinets with an expiration date of April 2024. One of the five bags did not have a protective plastic cover. CN1 confirmed that the five bags were past their expiration date and should have been discarded.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, as evidenced by 2 medication errors observed out of 28 opportunities for errors, for an error rate of 7%. Safe and timely medication administration practices are essential for the health and well-being of the residents. As a result of this deficient practice, two residents were placed at risk of negative outcomes due to medication errors. This deficient practice has the potential to affect all residents in the facility taking medications administered by staff. Findings include: 1) On 05/02/24 at 08:43 AM, observed medication pass with Registered Nurse (RN)8 as he prepared and gave medications to Resident (R)14. Observed RN8 prepare R14's Polyethylene Glycol (a laxative) 17 grams (gm)	F 759	F759 1. RN #8 was in-serviced regarding leaving medications at bedside and the appropriate administration of medications with meals by the UM. Resident #31 and #14's medications are being administrated appropriately as ordered. 2. Facility residents receiving medications have the potential to be affected by the alleged practices. 3. Licensed nurses were in-serviced regarding leaving medications at bedside and giving medications with meals by the UM/designees. In-services will be ongoing as needed. 4. UM/designees will monitor compliance through medical record reviews and medication administration observation	6/12/24

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F 759	Continued From page 21 using 8 ounces of water, split into two 4-ounce cups. One cup of prepared liquid was administered with R14's other oral medications. The second cup of prepared liquid (with half of the Polyethylene Glycol dose) was left at the bedside with R14 while RN8 left the room to prepare and administer medications to R31. On 05/02/24 at 09:51 AM, an interview was done with Unit Manager/Charge Nurse (CN)1 at the nurses' station. CN1 confirmed that medications should not be left at the bedside. When CN1 was asked specifically about Polyethylene Glycol, she responded, "that is a medication so it should not be left at the bedside." Review of Section 7.5, Medication Administration Orals policy, dated 01/23, noted the following: "Administer medication and remain with resident while medication is swallowed." Review of R14's provider orders revealed no orders for self-administration of any medications. 2) On 05/02/24 at 08:55 AM, observed RN8 prepare and administer medications to R31, among them was his Metformin 1000 milligrams, due at 09:00 AM. When RN8 entered R31's room with his medications, it was observed that there was no breakfast tray at his bedside. At 09:10 AM, confirmed with R31 that he had long since completed breakfast. During a review of R31's provider orders, the following was noted regarding his Metformin 1000mg:	F 759	rounds weekly for a minimum of 12 weeks or until substantial compliance is achieved. The DON will bring the results of these audits to the monthly QAPI meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	

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F 759	Continued From page 22 "Special Instructions: give with meal."	F 759		
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, interviews and record review, the facility failed to ensure food and drink items were stored in accordance with professional standards for food service safety. This deficient practice has the potential to affect all residents who have their meals served by the facility placing them at risk for food-borne illnesses. Findings include: On 04/30/24 at 10:03 AM, initial tour of the off-site kitchen conducted with the Nutrition Service	F 812	F812 1. The open and unlabeled foods and drinks found during the survey were disposed of when identified. 2. Facility residents have the potential to be affected by the alleged practices. 3. The storage and refrigeration areas were audited to ensure compliance of proper opened dates. Dietary and nursing staff were in-serviced regarding appropriately labeling open/discard dates	6/12/24

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 23 Director (NSD). During the inspection of the walk-in refrigerator, an opened one-gallon jug of milk was found without an open and discard date. NSD confirmed that the opened jug of milk was not labeled properly. Another refrigerator was inspected just outside the walk-in refrigerator. Two opened bottles of juice and two opened jars of mayonnaise were found with no open and discard dates. NSD confirmed that the items were not labeled properly and said that the staff are usually good at making sure all food items are labeled as soon as they are opened. Inspected freezer near the food preparation area, found a partially covered box of cheesecake with no open and discard date. NSD confirmed that all opened food and drink items should be labeled with the open and discard dates, and all items stored in the refrigerator and freezer should be covered. On 05/02/24 at 09:59 AM, inspected nourishment refrigerator in the front wing of the facility with Certified Nurse Aide (CNA) 19. Found an open container of sports drink and a bowl of food covered with foil. Both items were labeled with the residents' names but there were no open and discard dates noted. Asked CNA19 how long are the food items good for if kept in the refrigerator. CNA19 said three days. When asked how he would know if three days have passed since there was no open date noted on the food items, CNA19 said he will ask the residents since both were verbally responsive. Review of the facility policy titled, "Labeling and Dating Policy" conducted. The policy stated, ". . . If food is held for more than 24 hours, it shall be clearly marked to indicate the date or day by which the food item shall be consumed on the premises, sold or discarded. . ." The policy	F 812	on food stuffs and drinks by the UM/Dietitian/designees. In-services will be ongoing as needed. 4. UM/designee will audit the unit refrigerators through daily observation rounds to ensure compliance. Dietary staff will audit the dietary food storage and refrigeration areas through daily observation rounds to ensure compliance. UM/designees and the Dietitian will monitor compliance observation rounds weekly for a minimum of 12 weeks or until substantial compliance is achieved. The Dietitian and the UMs will bring the results of these audits to the monthly QAPI meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	

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F 812	Continued From page 24 included a table with a list of food and drink items and stated, "Items with use by date, defer to that date UNLESS opened, then use the policy below. . ." Under the "3 Days" column, it included "Hot or cold food leftover". Under the "7 Days" column, it included "Milk, Juices/Iced Tea". Under the "30 Days" column, it included "Mayonnaise."	F 812		
F 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the	F 847		6/12/24

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F 847	Continued From page 25 right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, record reviews and review of policy, the facility failed to ensure that two Residents (R)23, R25 of seven residents sampled understood the Binding Arbitration Agreement. As a result of this deficiency, R23, R25 did not fully understand the details of the Agreement. Findings include: R23 interviewed on 05/01/24 at 02:45 PM, stated that she did not remember signing the Binding Arbitration Agreement. Also, did not know what the Agreement was about. Review of Electronic Health Record (EHR) showed that R23 was admitted to the facility 05/22/23 and signed the Binding Arbitration	F 847	F847 1. Residents #23 and #25 had the arbitration agreement explained to them by the Administrative Assistant and were given the opportunity to withdraw their consent. 2. Facility residents have the potential to be affected by the alleged practices. 3. The Administrative Assistant and Social Services were in-serviced by the Administrator regarding explaining the Arbitration Agreement to residents on admission and as needed. In-services will be ongoing as needed. 4. Social Services Director/designees will	

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F 847	Continued From page 26 Agreement 05/28/23. R25 interviewed on 05/01/24 at 03:10 PM, stated that she signed all admission papers but did not remember the discussion of the Binding Arbitration Agreement. Also, R25 was not familiar with any details of the Agreement when presented to her. Review of EHR showed that R25 was admitted to the facility on 05/18/23 and signed her own Binding Arbitration Agreement 05/28/23. Staff interview on 05/03/24 at 10:30 AM, Administrative (Admin) Assistant said the facility follows the Binding Arbitration Agreement policy during the admission process for all residents. Review of facility policy on Binding Arbitration Agreements read; Policy, This facility asks all residents to enter into an agreement for binding arbitration. We do not require binding arbitration as a condition of admission to, or as a requirement to continue to receive care at this facility ... Policy explanation and compliance guidelines; When explaining the arbitration agreement, the facility shall: a. Explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at this facility. b. Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. c. Ensure the resident or his or her representative acknowledges that he or she understands the agreement ...	F 847	monitor compliance through medical record reviews and resident interviews weekly for a minimum of 12 weeks or until substantial compliance is achieved. The Administrator will bring the results of these audits to the monthly QAPI meeting for review and recommendations for a minimum of 3 months or until substantial compliance is achieved.	