STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HI02LTC056H	A. BUILDING: _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE HO ALOHA	2670 PACIFIC HEIGHTS ROAD HONOLULU, HI 96813

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4 000	11-94.2-0 Initial Comments A re-licensure survey was conducted by the State Agency, Office of Health Care Assurance on May 22, 2025. Complaint and Facility Reported Incidents (FRIs) were also investigated. The facility was found not to be in compliance with the requirements of Hawaii Administrative Rules, Title 11 Chapter 94.2, Nursing Facilities. FRI #11173- In compliance FRI #11392- In compliance FRI #11365- In compliance FRI #11012- In compliance FRI #11524- Not in compliance FRI #11660- Not in compliance Complaint #11134- In compliance Census- 53 residents. Sample size- 8 residents.	4 000		
4 725	11-94.2-29 (a) Resident abuse, neglect and misappropriation a) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Statute is not met as evidenced by: Based on interviews, record review and review of the facility's abuse policy, the facility failed to protect the right to be free from physical restraint for one of two residents (Resident (R) 3) investigated for facility reported incident of alleged abuse. As a result of this deficient practice, R3's patient's right was violated and sustained avoidable injury. Findings Include:	4 725		

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4 725	Continued From page 1 On 05/12/25 at 08:43 AM, the Office of HealthCare Assurance (OCHA) received a Facility Reported Incident (FRI) # 11660 of an allegation of abuse, involving Agency Nurse Assistant (ANA) 1 and R3. The report documented Certified Nurse Assistant (CNA) 1 heard someone shouting, "help me", entered R3's room, and saw ANA1 trying to finish her rounds. R3 stated "I want her to leave" then complained that her hand hurt. CNA1 informed Charge Nurse (CN) of the incident. CN stated during her assessment, R3 appeared teary-eyed and complained that her left hand hurt. R3 informed CN, someone grabbed her hand and now, she could not move her fingers. Director of Nursing (DON) and Social Worker (SW) interviewed R3 and found R3 had bruising on the top of her left hand and the resident's pain intensity level was 9 out of 10, 10 being severe pain, often dominates your senses and can be debilitating. An X-ray of R3's left-hand X-ray confirmed there was no fracture, and the resident had sustained soft tissue injuries only. ANA1 was allowed to give her statement, then was asked to leave the facility. On 05/22/25 at 10:00 AM, reviewed ANA1's statement of the incident. ANA1 noted R3 accused her of purposely spilling water on R3. R3 eventually became combative, trying to hit her. ANA1 stated that she dealt with many combative residents alone in the past and did what she always did and crossed their arms over their chest to keep them from hurting her and themselves. In ANA1's written statement, she documented she grabbed R3's hand after R3 punched her side, then R3 pulled her hand away from ANA1. On 05/22/25 at 01:00 PM, interview with DON completed. DON stated that R3 can be	4 725		

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4 725	Continued From page 2 combative at times and ANA1 did not know how the facility dealt with combative residents. DON told ANA1 the facility would let a combative resident calm down first before providing further care. DON confirmed that ANA1 still continued to change R3's brief by crossing R3's arm so that she could not move. DON stated that ANA1 told her that she was doing this in the mainland, and it was effective so ANA1 continued this practice. When DON was asked what type of training ANA1 in dealing with combative residents, DON stated that she was not sure, and that the agency should have covered that training. DON agreed that ANA1crossing R3's arm was a form of physical restraint and R3's left hand bruising and pain could have been avoided.	4 725		
4 730	11-94.2-29 (b) Resident abuse, neglect and misappropriation (b) All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source or origin, and alleged misappropriation of resident property shall be reported immediately to the administrator of the facility, and to other officials in accordance with state law through established procedures. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to notify law enforcement of alleged abuse for one of two residents (Resident (R) 3) investigated for the facility reported incident of alleged abuse. This deficient practice affects the appropriate authorities from being involved and providing the necessary support to assist facility in abuse investigation and prevention. Finding Include:	4 730		

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4 730	Continued From page 3 On 05/12/25 at 08:43 AM, the Office of HealthCare Assurance (OCHA) received from the facility an alleged abuse incident involving Agency Nurse Assistant (ANA) 1 and R3. The facility notified the physician, responsible party, Administrator, Adult Protective Services (APS), and OCHA, but did not notify law enforcement of the incident. On 05/21/25 at 01:00 PM, interview with Director Nursing (DON) completed. DON confirmed law enforcement was not notified of the incident, and she was not aware law enforcement needed to be called for an alleged abuse. Review of the facility's policy, "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" documented, "2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following person or agencies: e. Law enforcement officials."	4 730		
4 760	11-94.2-36 (a) Admission, transfer and discharge (a) There shall be written policies and procedures available to staff, residents, and the public that govern: (1) All services provided by the facility; (2) The admission, transfer, and discharge of residents; and. (3) Notification to the resident, resident's representative, and the state long term care ombudsman of transfer or discharge initiated by the facility.	4 760		

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4 760	Continued From page 4 This Statute is not met as evidenced by: Based on record review, staff interview and review of policy, the facility did not meet the program requirement to notify the State Long-Term Care (LTC) Ombudsman, of transfer or discharge initiated by the facility, for one Resident (R) 2 of one resident sampled. As a result of this deficiency, there was increased risk for an improper transfer or discharge. Findings Include: Review of Electronic Health Record (EHR) showed R2 was admitted on 01/18/24 with a diagnosis including Dementia, High Cholesterol, Malignant Neoplasm of Bronchus or Lung, Myelofibrosis, Diabetes, High Blood Pressure, Chronic Kidney Disease ... A high potassium level was noted on 10/10/24 and R2 was transferred to the Emergency Department and later admitted to the hospital. Staff interview on 05/21/25 at 12:40 PM, Director of Nursing (DON) revealed that the facility did not have a process to notify the State LTC Ombudsman of transfer or discharge initiated by the facility. DON said they were not aware of this requirement but would work on making the necessary change. Review of facility policy on Discharge Summary and Plan read; Policy Statement, when a resident's discharge is anticipated a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. Policy Interpretation and Implementation, when the facility anticipates a resident's discharge to a private residence, another nursing care facility	4 760		

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4 760	Continued From page 5 (i.e. skilled, intermediate care, ICF/IID, etc.), a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident ... A copy of the following will be provided to the resident and receiving facility, and a copy will be filed in the resident's medical records: an evaluation of the resident's discharge needs, the post-discharge plan and the discharge summary.	4 760		
4 870	11-94.2-41 (a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation, interviews, and review of the facility's policy, the facility failed to ensure temperatures for a walk-in refrigerator and walk-in freezer were monitored and within the recommended safe temperature ranges and open perishable food items were properly label with an open/discard date to conserve nutritional	4 870		

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4 870	Continued From page 6 value and prevent using spoiled food. This deficient practice puts residents at risk for complications for foodborne illness. Findings Include: On 05/20/25 at 08:30 AM, walkthrough of the kitchen with Dietary Manager (DM) and Dietary Aide (DA) completed. Observed the walk-in refrigerator and walk-in freezer temperature log was blank (indicating the temperature was not checked) on 05/02/25, 05/09/25, 05/16/25, and 05/17/25. In a separate refrigerator, observed a quart of egg white carton open with no open date or discard date label. Concurrent observations and interview were conducted with the DM and DA confirmed that the temperatures for the walk-in refrigerator and freezer were missed on multiple days and that staff forgot to check it. DA stated checking the temperatures are important to ensure food from getting spoiled. DA and DM also confirmed that any open perishable items in the refrigerator should be labeled to let staff know when it was opened and when to throw it away. Review of the facility's "Food Receiving and Storage" policy, notes: "7. All food stored in the refrigerator or freezer will be covered, labeled, and dated ("use by" date) ...13. c. refrigerators must have working thermometers and be monitored for temperature according to state-specific guidelines ...e. Other opened containers must be dated and sealed or covered during storage."	4 870		
4 950	11-94.2-43 (c) Interdisciplinary care process	4 950		

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4 950	Continued From page 7 (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to review and revise the care plan for one out of six residents (Resident (R) 5) investigated for facility reported incident and closed record review. The facility failed to revise the care plan to include R5's increase need with meal assistance due to a decline of functional abilities and overall health. This deficient practice puts residents at risk for not receiving the appropriate care and help needed to attain their highest practicable level of physical well-being. Findings Include: On 02/26/25 at 10:30 AM, Office of Healthcare Assurance (OCHA) received a Facility Reported Incident (FRI) #115524 which documented on 02/25/25 at 01:15 PM, Certified Nurse Assistant (CNA) 1 went to R5's room to check if R5 was finished with his lunch. R5 requested for a hot coffee and CNA1 gave the coffee to the resident, then 15 minutes later CNA1 went back to R5's room to provide care to the resident and discovered R5 had spilled the hot coffee on the chux, T-shirt, and his body. R5 had burns/scalding on the left lateral thigh area, left side of rib cage, and left antecubital area. Record review to R5's Electronic Health Record (EHR) completed on 05/13/25. Review of the Monthly Summary Assessment completed on 01/27/25, in the dietary section, documented R5	4 950		

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4 950	Continued From page 8	4 950		

needed extensive physical assistance (resident performed part of the activity but staff provide weight bearing assistance, such as lifting the resident's arm to assist with eating or drinking). Review of the care plan noted a focus of Activities of Daily Living (ADL) self-care performance deficit related to Activity Intolerance, fatigue, limited mobility, but did not include interventions to assist R5 with meals/drinking.

On 05/21/25 at 01:00 PM, interview with Director of Nursing (DON) completed. DON stated that R5 was on Hospice and was dependent on staff for ADLs, but thought R5 could still feed himself. DON stated R5 had episodes of getting better, then there were times when R5 would not eat. DON noted that R5 had a decline in his health status. Reviewed R5's Monthly Summary Assessment and care plan with DON and confirmed, R5 should have been assisted with the coffee and the care plan should have been revised to reflect R5's increase need for assistance. DON further stated that the revising the care plan is important as it directs the care of the resident.

Review of the facility's policy, "Care Plans, Comprehensive Person-Centered", documents, "7. b The care planning process will include an assessment of the resident's strengths and needs...8b. The comprehensive, person-centered care plan will describe the services to be furnished to attain or maintain the resident's highest practicable physical ...well- being. O. Reflect currently recognized standards of practice for problem areas and conditions ...13. Assessments of residents are ongoing, and care plans are revised as information about the resident and the residents' conditions change ...14. The Interdisciplinary Team must review and

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4 950	Continued From page 9 update the care plan: a. When there has been a significant change in the resident's condition."	4 950		