

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 (OHCA) on 02/25/25-02/28/25. The facility was not in compliance with 42 CFR 483 Subpart B. Facility Reported Incidents (ACTS 11502 and 11254) were also investigated with no deficiencies identified.  Survey Census: 91 Sample Size: 32	F 000		
F 550 SS=D	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 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.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>	
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 550	<p>Continued From page 1</p> <p>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.</p> <p>§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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure one resident was treated with dignity and respect while he waited for an hour to eat his lunch during a random dining observation on the Keola' Mau unit. The deficient practice caused discomfort for the resident while he watched other residents on the unit eating their lunch and he had to wait.</p> <p>Findings include:</p> <p>Observations on the Keola 'Mau unit dining room on 02/25/25 at 12:00 PM. The lunch trays were brought to the unit. Staff began pulling trays from the cart and setting them up for the residents in the dining room. Some of the residents were being taken to the other dining room to eat their lunch.</p> <p>Observation at 12:15 PM, Resident (R) 28 was sitting in his wheelchair in the dining room in front of the nurse's station. R28 had his eyes open</p>	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 550	<p>Continued From page 2</p> <p>and was looking around the room. No tray present in front of him. Other residents in the room were receiving their trays and having them set up.</p> <p>Observation at 12:41 PM. R28 continued to be without his meal tray. The surveyor observed R28s lunch tray on the meal cart sitting in the hall. Observed the tray pushed to the back on the cart.</p> <p>Observation at 12:48 PM. R28 is awake in his chair looking around, all of the other residents are eating, or finished eating. One Certified Nurse Aide (CNA) 47 is feeding the resident behind R28, two other CNAs are seen walking around the unit. staff are observed walking around the unit, R28 was sitting in his chair. Observed two Activity Aides (AA) 1 and 2 were standing in the middle of the dining room. The surveyor asked them if they assist the residents to eat during the mealtimes. AA 1 said "sometimes". The surveyor asked the AA2 if the activity staff need permission from the nursing staff to assist the residents to eat. AA2 said, if the nursing staff ask us to assist the resident to eat, we will.</p> <p>Observed CNA47 bring R28 his tray from the cart and set on an overbed table at 12:53 PM. CNA set up the lunch plate and utensils for R28 and started assisting him to eat.</p> <p>Interview with Registered Nurse (RN) 25 on 02/25/25 at 12:55 PM. The surveyor asked her what the activity staffs' responsibilities during mealtimes are and if they assist the residents for eating. What are the expectations of the nursing staff. RN25 said they can feed the residents if they are trained, and the activity staff can set up the resident with their tray. Once the nursing staff</p>	F 550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>	
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 550	<p>Continued From page 3</p> <p>see they are set up, they know that the resident is ready to eat lunch and will assist them. The surveyor shared with R28 the observation on the unit and that R28 waited for an hour to receive his lunch after most of the other residents on the unit finished their lunch.</p> <p>Reviewed the minimum data set (MDS) admission assessment dated 01/14/25. R28 is dependent on staff to eat. The helper does all of the effort.</p> <p>Reviewed the Care plan on 02/28/25. Resident is at risk for malnutrition or nutrition-related problems related to (r/t) Parkinson's disease, dementia, increased nutritional needs due to large stature, dysphagia requiring altered texture diet, dependent on staff for nutrition/hydration. The resident needs a calm, quiet setting at mealtimes with adequate eating time, total assist at meals.</p> <p>Interview with Licensed Practice Nurse (LPN) 55 on 02/28/25 at 09:40 AM. The surveyor shared an observation on the unit on 02/25/25 of R28 waiting an hour for his lunch. LPN55 said she was aware that R28 waited a very long time on Tuesday for his meal and that everyone on the unit is responsible to assist the residents who need assistance with the setup of their trays. If the staff are trained, they can assist the resident to eat if the resident doesn't have difficulty swallowing.</p> <p>Interview with the Director of Nursing (DON) on 02/28/25 at 11:28 AM. The DON said when the trays are brought to the unit, the activity and hospitality staff pass trays to the residents who can feed themselves. The residents who are independent will get their trays first and the</p>	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 550	Continued From page 4 residents who need assistance are set up and assisted by the staff. The activity staff are able to assist the residents with eating as long as they have been trained.  Facility Dignity Policy revised dated 09/26/24 reviewed on 02/28/25. Each resident has the right to be treated with dignity and respect ...enhancing the resident's self-esteem, self-worth ...Promoting resident independence and dignity while dining ...  Feeding, long-term care policy revised 09/12/2024 reviewed on 02/28/25 ...Feeding a resident in a respectable and patient manner, enhance the resident's nutritional status and psychosocial well-being.	F 550		
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 or theft.	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 584	<p>Continued From page 5</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§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</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and policy reviews, the facility failed to provide a clean and homelike environment in a random number of rooms on two units. The floors in the resident's rooms had buildup of dirt and scuff marks. In one resident rooms bathroom, there was a strong urine odor and yellow stains on the floor. The deficient practice increases the risk of infection and decreases the resident's psychosocial well-being.</p> <p>Findings include:</p> <p>1) The following random observations were made between 02/25/25 to 02/28/25.</p>	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 584	<p>Continued From page 6</p> <p>In room 203 on 02/25/25 at 11:00 AM. The skid strip next to bed was peeled up into a curled strip that may be a trip hazard. The bathroom has black scuff marks all over the floor with dirt and dust. The entrance to the room at the door has a large amount of dust, and dirt stains on the tiles.</p> <p>In room 205 on 02/25/25 at 11: 03 AM, the floor tiles next to the bed near the bathroom had black dirt and dust on the tiles. In the bathroom the floor tiles were soiled with black dirt and scuff. A strong urine odor was present in the bathroom. A plastic urine collection container was sitting on the back of the toilet.</p> <p>In room 211 on 02/26/25 at 11:43 AM observed dust, dirt, and black marks on the bathroom floor.</p> <p>Interview with Resident (R) 196s Family member (FM) 1 in room 205 while visiting with R196 in his room. The surveyor asked FM1 if she felt that the room is quiet and clean enough. FM1 pointed to the floor and said, they need to clean this, pointing to a large, soiled area on the floor near the foot of the bed. It used to be nicer in here, but maybe they are short staffed.</p> <p>Observation of the Housekeeper (HK) 11 on the 300 wing on 02/27/25 at 09:27 AM Observed the cleaning cart with microfiber rags in the bucket and no water. HK11 picked up several yellow plastic caution signs and took them to a storage room.</p> <p>Interview with HK11 on 02/27/25 at 09:36 AM on the Keola' Mau unit near the nurse's station. The surveyor asked her what her work assignment in the facility was for the day. HK11 said that she works in the laundry room and also on both Units.</p>	F 584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 584	<p>Continued From page 7</p> <p>HK11 explained that she starts her day putting up the yellow signs, then she wipes down the common areas on the unit. Next, she cleans the bathrooms, wiping down everything, inside and outside. She uses the orange cloth to wipe the furniture; the blue towels are only used in the bathrooms. In the bathrooms the sinks are cleaned then the rubbish cans are emptied, then the toilet. HK11 stated that she mops the floors every day. The surveyor asked her if the Supervisor goes behind her to check on her work. HK11 stated, yes, she does and will tell us if there is anything else that we need to do. HK11 showed the surveyor a cleaning checklist with each location where she signs off the time it was cleaned. Listed were the Resident rooms, nurses station, etc. listed on the sheet. She expressed that if the residents are in the room eating, they are not allowed to mop or use any chemicals.</p> <p>Observation and interview with the Director of Nursing (DON) on 02/28/25 at 09:22 AM the surveyor showed the DON the soiled and scuffed floors in rooms 203, 205 and 211. The DON agreed there was a strong odor of urine in room 205s bathroom. The DON said they have been asking the housekeeping staff to clean the floors and that the house keeping department is working on a strip/ wax plan.</p> <p>Observation and interview with the Housekeeping Supervisor (HS) on 02/28/25 at 09:45 AM on the Keola' Mau unit, 200 room wing. The surveyor showed the HS the rooms with the dirty and scuffed tile floors. The surveyor showed the HS the bathroom in 205 with the strong urine odor. The HS agreed there was a very strong odor of urine and noted a yellow stain visible on the floor next to the toilet. The HS said the staff need to</p>	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 584	Continued From page 8 do a better job cleaning the bathroom. The HS stated that she is working on a plan to have the floors in each of the rooms cleaned and will address the bathrooms with the housekeeping staff.  2) On 02/26/25 at 10:36 AM, observed the floors of rooms 501, 504, 508 and 510 with a dark residue. Brought observations to the attention of Registered Nurse (RN)5 who inspected the floors of all four rooms mentioned. RN5 acknowledged that the floors had a dark residue and said, "They look dirty and it does not look good." RN5 said she will let the housekeeper know so they can "strip and wax the floors."  On 02/28/25 at 09:30 AM, inspected the floors of rooms 501, 504, 508 and 510 with the Director of Nursing (DON). DON confirmed that the dark residue on the floors is built-up dirt, and they will need to strip the floors of the old wax and build-up of dirt before applying another layer of wax to keep them clean.  Housekeeping services policy revised 08/09/22 reviewed on 02/28/25. The resident has a right to a safe, clean, comfortable, and homelike environment ...Routine Cleaning. 1. Keep housekeeping surfaces visibly clean on a regular basis ...Resident rooms. A. Clean high-touch surfaces at least daily to include handwashing sinks and floors ...	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.	F 641			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 641	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure that the Discharge Assessment for one of three Residents (R)94 sampled for closed records review, accurately reflected the resident's discharge status.</p> <p>Findings include:</p> <p>On 02/26/25 at 02:24 PM, review of R94's Electronic Health Record (EHR) was conducted. R94 was admitted to the facility for short-term rehabilitation services on 01/09/25 and discharged on 01/25/25. R94 was sampled as a closed records review for discharge to the hospital. Review of the last "Progress Notes" entry on 01/25/25 at 09:37 AM stated, "Resident was discharged home, left unit at 0935 [09:35 AM], escorted by CNA [Certified Nursing Assistant] to parking lot and left in stable condition. . ."</p> <p>Review of Minimum Data Set (MDS) Nursing Home Discharge with an Assessment Reference Date (ARD) of 01/25/25 noted R94 was documented as discharged to "Short-Term General Hospital (acute hospitals, IPPS [inpatient prospective payment system])" under Section A, question A2105 Discharge Status.</p> <p>On 02/26/25 at 10:36 AM, a concurrent interview and record review was conducted with Registered Nurse (RN)6 and Director of Nursing (DON) at the nurse's station. Asked RN6 if R94 was discharged home or to the hospital. RN6 said she remembered R94 since she was the one that discharged her and that she was discharge home. Reviewed MDS Nursing Home Discharge</p>	F 641			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 641	Continued From page 10 document with RN6 and DON, both said question A2105 Discharge Status was answered incorrectly since R94 was discharged home and not to the hospital.	F 641			
F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 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 interviews and record review, the facility failed to implement interventions to treat one of one Resident (R)37 in the sample for constipation. As a result, R37 was placed at risk of increased pain and discomfort. This deficient practice has the potential to affect all the residents in the facility at risk for constipation.</p> <p>Findings include:</p> <p>R37 was a 76-year-old resident admitted on 07/12/22 for long-term care. Diagnoses included but not limited to Osteoarthritis, depression, and constipation.</p> <p>On 02/26/25 at 11:32 AM, an interview was conducted with R37 in her room. R37 said she had constipation last week where she did not have a bowel movement (BM) for four days. Asked R37 if she takes any stool softeners. R37</p>	F 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 11 said the nurses give her one every morning but does not remember the name. When asked if the constipation causes her any pain or discomfort, R37 said, "My stomach not sore."  Review of R37's Electronic Health Record (EHR) was conducted on 02/26/25. R37 had the following laxatives (medications that treat constipation) ordered: Sennosides-Docusate Sodium 8.6-50 milligram (mg) tablet daily; Sennosides 8.6 mg as needed for no BM after 2nd (second) day; and Bisacodyl Suppository 10 mg rectally as needed for no BM after 3rd (third) day. Review of R37's "Bowel and Bladder Elimination" log in the EHR revealed that from 02/17/24 to 02/20/24, she did not have a BM for four days. Review of the Medication Administration Record (MAR) for February 2025 revealed that Sennosides and Bisacodyl Suppository were not administered as ordered when R37 did not have BM for four days.  On 02/27/25 at 10:39 AM, concurrent interview and record review was conducted with Registered Nurse (RN)6 at the nurse's station. Reviewed the Bowel and Bladder Elimination log in the EHR for the past 30 days with RN6 and asked if R37 had any episodes of constipation. RN6 said there was a period of four days where R37 did not have BM, from 02/17/25 to 02/20/25. Asked RN6 if any PRN (as needed) laxatives were given to R37 on those days. RN6 reviewed the current MAR and said R37 should have been given Sennosides on 02/19/25 after the second day without BM and Bisacodyl Suppository after the third day without BM on 02/20/25.	F 684			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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	<p>Continued From page 12</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§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.</p> <p>§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 observation, record review and interview the facility failed to assure staff were cleaning the kitchen ice machine to prevent any growth of infectious organisms on a regular basis. The facility failed to assure staff were documenting the kitchen dishwasher was reaching the 120 degrees Fahrenheit (F) for the wash cycle observed and documented each meal, breakfast, lunch and dinner. The deficient practice puts all residents and staff at risk for exposure to infectious organisms who are provided with ice or meals from the kitchen.</p> <p>Findings include:</p> <p>On 02/25/25 at 10:55 am during initial tour with Food Service Director (FSD) observed the ice</p>	F 812			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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	<p>Continued From page 13</p> <p>machine in the kitchen. Opened the top of the ice machine and observed it had dark gray to black debris on the upper inside of the ice machine. Interviewed FSD at this time and asked who cleans the ice maker and he stated it is cleaned by maintenance.</p> <p>On 02/27/25 at 11:35 AM a re-visit was conducted of the kitchen to observe the trayline. After trayline was observed reviewed dishwasher log and found the facility staff are recording temperatures in the 80's - 120's for the wash cycle. Inquired about the temperature log of FSD and requested to observe a wash cycle with the dishwasher. FSD ran the dishwasher and the highest temperature observed was 108 degrees F. Review of the "Low Temperature Dish Machine Log" for "Feb 2025" states "During the COVID-19 outbreak, along with name of vendor, we are requesting PPM's to be at 100 PPM [parts per million] and your rinse temperature to remain at a minimum of 120 degrees." Reviewed this with FSD. Inquired with FSD what the temperature has to be to clean the dishes. FSD was able to scan the QR code on the dishwasher with his cellular phone and get the specifications from the vendor regarding this dishmachine. FSD shared the dishwasher has to operate at wash (minimum) of 120 degrees F and sanitizing rinse (minimum) of 120 degrees F. Surveyor requested FSD contact the vendor to discuss temperatures required for their low temperature sanitizing dish washer.</p> <p>On 02/27/25 at 01:30 PM Administrator shared an email from their dish washing machine vendor. FSD and Administrator were able to contact the vendor who clarified by email dated 02/27/25 at 01:07 PM the following "With the name of vendor</p>	F 812			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 14 dish machine located at Name of Facility, it is totally acceptable for the dish machine to start a cycle under a 120 degrees at times and ending with 120 plus degrees with a chemical sanitizer at the end with a test between 50-100 ppms." Inquired with Administrator if the facility has had a foodborne illness and she denied this.  On 02/28/25 at 09:35 AM interviewed Maintenance Manager who was able to explain the deep cleaning process his department does when they clean the ice machine. Maintenance Manager stated they use a sanitizing and descaling solution to clean the emptied ice machine which is done every six months with the last cleaning done in October 2024. Maintenance Manager stated the day to day cleaning is done by the kitchen staff, this is not something that maintenance does currently.  On 02/28/25 at 09:45 AM interviewed Administrator and asked if the kitchen staff are responsible for cleaning the ice machine and she stated she would find out if this task is on the cleaning check list and provide a copy to me.  On 02/28/25 at 10:01 AM Administrator was able to provider a copy of the kitchen cleaning checklist. The kitchen cleaning checklist was reviewed and ice machine cleaning was not listed and Administrator confirmed it does not include ice machine cleaning. Administrator stated this was somehow dropped or communicated and she said the ice machine cleaning was going to be added to the checklist.	F 812			
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)	F 842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 842	<p>Continued From page 15</p> <p>§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p>	F 842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 842	<p>Continued From page 16</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <ul style="list-style-type: none"> <li>(i) The period of time required by State law; or</li> <li>(ii) Five years from the date of discharge when there is no requirement in State law; or</li> <li>(iii) For a minor, 3 years after a resident reaches legal age under State law.</li> </ul> <p>§483.70(h)(5) The medical record must contain-</p> <ul style="list-style-type: none"> <li>(i) Sufficient information to identify the resident;</li> <li>(ii) A record of the resident's assessments;</li> <li>(iii) The comprehensive plan of care and services provided;</li> <li>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</li> <li>(v) Physician's, nurse's, and other licensed professional's progress notes; and</li> <li>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</li> </ul> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interviews, the facility failed to maintain complete and accurate medical records in accordance with acceptable standards and practice for three of 21 residents (Resident (R)37, R295 and R56) in the sample. Specifically, the Advance Health Care Directives (AHCD) did not include end-of-life decision choice and resident-specific information in the orders for pain assessment and management were left blank. This deficient practice has the potential to prevent the residents from achieving their individual goals and objectives.</p>	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 842	<p>Continued From page 17</p> <p>Findings include:</p> <p>1) On 02/26/25 at 11:22 AM review of R37's Electronic Health Record (EHR) was conducted. R37 is a 76-year-old resident admitted on 07/12/22 for long-term care. R37 had an AHCD scanned into the EHR that was signed by R37's brother, and surrogate decision maker on 11/04/22. On page four of the document under "End-Of-Life Decisions", where the choices are "(a) Choice Not To Prolong Life . . . (b) Choice To Prolong Life . . .", both checkboxes were left blank. Further review of the EHR revealed that in the "Admission Record", stated under "Advance Directive" was, "Full Code with Full Treatment."</p> <p>On 02/27/25 at 10:21 AM, a concurrent interview and record review conducted with Registered Nurse (RN)6 at the nurse's station. Asked RN6 what was R37's code status. RN6 checked the EHR and said R37 was full code. Asked RN6 if that information was documented in the AHCD. RN6 checked in the EHR and acknowledged that the section of the ACHD where the resident's end-of-life decision should be documented was left blank. RN6 checked the documents in the physical chart and found a copy of R37's POLST (Provider Orders for Life-Sustaining Treatment) dated 07/13/22 that documented R37 was a full code. RN6 added that he will find out why this was not documented in the AHDC.</p> <p>On 02/27/25 at 10:52 AM, concurrent interview and record review was conducted with the Social Services Director (SSD) at the nurse's station. SSD reviewed the AHCD and confirmed that the document was not completed to include guardian's choice for end-of-life decision. SSD</p>	F 842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 842	<p>Continued From page 18</p> <p>said they will have the guardian come in to complete the document.</p> <p>2) On 02/27/25 at 10:10 AM, while reviewing the physician's orders in R37's EHR with RN6, noted that an active order dated 07/11/22 had information that was left blank as stated: Acceptable level of pain: Numeric Scale _____/10 Location of pain: 1. _____ 2. _____ 3. _____ Numeric pain scale three times a day Attempt non-med interventions prior to administering PRN pain medications: 1. _____ 2. _____ 3. _____ 4. _____ Do not arouse from sleep. Do not exceed 3,000 mg Acetaminophen in a 24 hour period from all sources.</p> <p>Numeric scale for acceptable pain level, location of pain, and non-medical interventions to attempt prior to giving pain medications were left blank. Asked RN6 why there were missing information in the physician's order. RN6 said the order is for the nurses to assess the resident's acceptable pain level and based on that, pain medication will be administered as ordered.</p> <p>On 02/27/25 10:51 AM, concurrent interview with Director of Nursing (DON) and RN6 conducted at the nurse's station. Reviewed above order with DON and she confirmed that the order was missing resident-specific information so it was not completed as intended. RN6 added, "We'll get it corrected."</p>	F 842			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/28/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HALE ANUENUE RESTORATIVE CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 842	Continued From page 19 The same order was found in the EHR for R295 and R56. During a concurrent interview and record review with the DON in the conference room on 02/28/25 at 11:20AM, she confirmed that the order is not complete since it does not include the acceptable pain level as identified in the pain assessment, location of pain as identified by the resident and non-pharmalogical interventions to be carried out prior to administering medications.	F 842		