STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125024	A. Building B. Wing	02/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nuuanu Hale	2900 Pali Highway Honolulu, HI 96817

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37229 Based on observations, record review, and interviews with staff members, the facility failed to implement interventions, including adequate supervision, to reduce the risk of accidents for two of six sampled residents, Residents 23 and 36. As a result of this deficient practice, Resident (R)36 had multiple falls, with a fall resulting in the resident being taken to the emergency department for evaluation. Finding include: Resident (R)36 has an extensive history but not limited to hereditary musculoskeletal disease, blindness to the left eye secondary to a ruptured globe (repaired). Recurring depression/anxiety, cognitive decline with behavioral disturbances. Also hereditary spinocerebellar ataxia (type 3, [NAME]-[NAME] with recurrent falls and dysarthria.) Facility reported incident summary dated 01/10/23 at 12:30 AM in Ewa Hallway revealed R36 was found lying belly down with hands out in front of him and forehead touching the floor. Wheelchair was on top of resident and his chest belt was still strapped on. R36 was taken to a hospital emergency room by emergency medical services (EMS). Record documented that the resident lost consciousness and had a weak and thready pulse. Record review (RR) reveals fall events on: 09/30/22 - slid out of chair - no injury. 01/07/23 - Fall with abrasion to left forehead. 01/10/23 - Fall with loss of consciousness. 02/02/23 - Fall with a minor scratch to his forehead Observation on 02/01/23 at 09:05 AM, R36 was waiting in que for a shower. This surveyor noted that his toe was bleeding. Noted that R36's toes were dangling on the floor and leaving a trail of blood. Unit manager (UM)1 was notified. (continued on next page)

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.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation on 02/02/23 at 08:46 AM in the hall, R36 is in the hall in his wheelchair with his iPad. R36 is slouched down and tends to slide in his wheelchair. No wedge pillow was noted. No dedicated staff to supervise resident on a one-to-one basis. On 02/02/23 at 11:45 AM, interview with Registered Nurse (RN)6 stated that R36 had an unwitnessed fall this am before morning shift and sustained a minor scratch to his forehead. Interview with director of nursing (DON) about what the facility is doing about falls for R36. DON stated that the Physician (MD) is discontinuing his blood thinner. DON stated R36's mother is very involved and has ordered a special wheelchair that is custom fit to the resident, ordered in August but not available yet. Resident has refused a Geri-chair, vest restraint, changing rooms. Resident is brought to nursing station but will loosen lap belt and slide out of chair. Facility has had 1:1 sitting in the past. Mother comes in every afternoon and sits with him. Resident has been seen to propel himself onto the floor by staff. RR on 02/03/23 at 07:32 details R36 was seen on the floor on 02/02/03, surrounded by morning staff. CNA witnessed resident slide himself from the wheelchair onto the floor and falling forward face down, small laceration superior to left eyebrow, no bleeding, no change in LOC, called American Medical Response (AMR) for pick up. Interview on 02/03/23 at 07:56 AM with LPN 9, who is R36's nurse today. Queried LPN9 if she was aware of the fall. LPN9 stated that she was aware of the fall but had not had a chance to review it. LPN9 stated honestly, it's a matter of keeping him comfortable and entertained. Observation on 02/03/23 at 08:27 AM of nurse talking with R36. Immediately after nurse goes down the hall, R36, is calling out in hall to be pulled up. All staff in rooms, busy and unit clerk is the only person nearby. Observation on 02/03/23 at 09:22 AM of R36 who is loudly crying out I'm going to fall down. LPN9 responded to R36. 47783 2) R23 is a [AGE] year-old resident with Alzheimer's disease, dementia, history of falls and fractures, muscle weakness, orthostatic hypotension (sudden drop in blood pressure when standing from a seated or lying position), difficulty in walking and age-related osteoporosis (weakened bones). R23 also has a history of wandering. On 1/31/23 at 09:10 AM, observed R23 lying in bed with only her head and back directly on the bed, and both feet touching the floor. Registered Nurse (RN) 6 was in the room passing medications to another resident, asked if the resident needs to be positioned properly in the bed. RN6 replied that that's how R23 is and can get combative if they try and place her on the bed properly. On 02/02/23 at 10:45 AM, observed resident get out of bed unsupervised and unassisted, used front wheel walker (FWW) and walked to the toilet. After using the toilet, R23 proceeded to the elevator by herself using her FWW as the recreational therapy staff was bringing other residents down to the first-floor activities area. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review revealed that R23 had an unwitnessed fall in her room on 10/08/22 at 09:39 PM, unwitnessed fall in the hallway on 11/21/22 at 01:23 PM, witnessed (by a resident) fall in the hallway on 12/19/22 at 02:21 PM, and was trapped in the elevator by herself on 11/26/22 for approximately 15 mins and on 01/26/230 for approximately 50 minutes. Most recent Rocky Mountain Fall Risk assessment dated [DATE] described the resident as a moderate fall risk with no mobility concerns and impulsive actions. However, assessments for the following dates: 10/08/22 described R23 as high fall risk, requires assistance or supervision for mobility, transfers, or ambulation and lack of understanding of physical and/or cognitive limitations; 11/21/22 as high fall risk with unsteady gait, altered awareness on immediate physical environment, impulsive actions and lack of understanding of physical and/or cognitive limitations; and on 12/19/22 as high fall risk, requires assistance or supervision for mobility, transfers, or ambulation, altered awareness on immediate physical environment, and lack of understanding of physical and/or cognitive limitations. Review of care plan (CP) documented the resident was at risk for falls (11/06/21), and wandering (09/18/21). (Cross reference to F657 Care Plan Timing and Revision). On 02/02/23 at 11:04 AM, conducted an interview with RN6 and unit clerk (UC)10. Asked RN6 if they have a device to prevent R23 from accessing the doors, she confirmed that R23 does not have a wander bracelet. According to the UC10, they used to have wander bracelets but not anymore since they upgraded their doors. A key card is needed to open the door. The residents are still able to access the elevator, but all the doors downstairs also require a key card to open. On 02/03/23 at 10:27 AM, conducted an interview with Unit Manager (UM)1. Asked how closely is R23 being supervised when wandering in the hallway, UM1 responded: we try to keep an eye on her as much as we can resident goes to activities and does not need constant assistance able to walk around and has a fascination with the elevator. We tried to have her sit by the nurse's station, but she would still try to get up and walk away. We are not able to provide her with one to one supervision.