STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125019	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Care Center of Honolulu	1900 Bachelot Street 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to accurately assess one of three residents (Resident (R) 6) selected for review to reflect resident's health status upon returning from out on pass.Findings Include: Resident (R)6 is a [AGE] year-old male admitted to the facility on [DATE] and is currently receiving Intermediate Care Facility level of Care. Diagnoses included but not limited to congestive heart failure, nicotine dependence, osteoarthritis and diabetic neuropathy. On 04/22/26 at 11:00 AM, Office of Health Care Assurance (OHCA) received Facility Reported Incident (FRI) initial report with Intake #2991932. FRI noted that, .R6 self-reported a fall on 04/21/26 that occurred on 04/20/26 while out on pass from 11:18 AM and returned at 04:18 PM.On 04/21/26, head-to-toe skin assessment was conducted.skin and pain re-assessment identified multiple minor injuries, including a scratch to the right inner forearm measuring 0.9 cm by 0.5 cm, a skin tear with total flap loss to the left elbow measuring 1.7 cm by 1.9 cm with scant serosanguineous drainage, abrasions and intact blood blisters to the left dorsal first digit, and a skin tear to the right dorsal first digit measuring 0.6 cm by 1.5 cm.X-ray obtained in facility resulted on 4/22/26 indicating acute minimally displaced fractures involving the left 6th, 7th, 8th, 9th, and 10th ribs. On 04/23/26 at 09:34 AM, record review of electronic R6's electronic health record (EHR) was done. EHR reflected that, Registered Nurse (RN) 10 conducted head to toe and pain assessment on 04/20/26 at 04:18 PM. RN10 documented on form titled, Nursing Assessment before/after Resident Transport/Leave of Absence, Section C. Description of consult/Appointment stated, .Resident returned to facility via taxi at approximately 04:18 PM in stable condition following a personal errand with wife. A&Ox3, denies pain or discomfort upon arrival. No acute distress noted, No new skin issues noted. On 04/23/26 at 11:45 AM, an interview and record review were done with Administrator in the conference room. After reviewing R6 Electronic Health Record, asked Administrator if RN10 did an accurate assessment with R6, Administrator confirmed that RN10 did not accurately assess R6 on 04/20/26 upon coming back from Kuakini Emergency Room. Review of facility policy titled Resident Assessments with a revision date of 03/22 stated, . 1. Interdisciplinary team conducts timely and appropriate resident assessments.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide care in accordance with professional standards by not performing an accurate assessment of Resident (R)6 returning to the facility, and not taking actions to ensure family-supplied prescription medication was available for R7. As a result of this deficient practice, R6 received delayed medical attention after a fall, and R7 was placed at risk for adverse health effects for not taking prescribed medications. Findings include:Cross Reference to F641 - Accuracy of Assessments 1) Resident (R) 6 did not receive necessary treatment and intervention in a timely manner when R6 had a fall incident causing multiple skin abrasions and fractured ribs on 04/20/26 while R6 was out on pass. Registered Nurse (RN) 10 conducted head to toe and pain assessment on 04/20/26 but failed to observe multiple injuries, including a scratch to the right inner forearm measuring 0.9 cm by 0.5 cm, a skin tear with total flap loss to the left elbow measuring 1.7 cm by 1.9 cm with scant serosanguineous drainage, abrasions and intact blood blisters to the left dorsal first digit, and a skin tear to the right dorsal first digit measuring 0.6 cm by 1.5 cm. R6 was transferred to Kuakini Medical Center on 04/22/26 for further evaluation.Cross reference to F842 - Resident Records - Identifiable Information 2) Review of Intake # 2719441 stated R7 missed multiple doses of Eltrombopag Olamine (medication that boosts the production of a blood component to stop bleeding) in December 2025 after returning from the hospital and in January 2026 prior to discharge. The medication was not available from the facility-contracted pharmacy and was being provided by the family. The facility was provided with enough medication to last until January 19, 2026, which was his planned discharge date . Review of Electronic Health Record (EHR) revealed that R7 was a [AGE] year-old resident admitted to the facility for short-term rehabilitation services. Diagnoses included but not limited to immune thrombocytopenic purpura (disorder that can lead to bruising and bleeding), encephalopathy (a condition that causes brain dysfunction) and atrial fibrillation (irregular and fast heart rhythm). R7 was prescribed Eltrombopag Olamine 50 milligrams daily to be administered every Monday to Friday. On 12/16/25, R7 was transferred to an acute care hospital for gastrointestinal bleeding and evaluation after an unwitnessed fall and returned to the facility on [DATE]. Review of Medication Administration Record (MAR) for December 2026 done, Eltrombopag Olamine was not administered 12/18/25. Reason stated in the progress notes stated, . waiting on delivery from family. Review of MAR for January 2026 revealed that the medication was not administered from 01/05/26 to 01/14/26. Reason noted in the progress notes was that the facility was waiting for the family to provide the medication. On 04/23/26 at 08:58 AM, concurrent interview and record review was conducted with Registered Nurse (RN)12 at the nurses' station. Queried RN12 about the medication being provided by the family for R7 and the reason for the missed doses. RN12 stated that the reason for the missed dose on 12/18/25 was because the medication was placed in the discard box after he was transferred to the hospital. RN12 added that another RN later found the medication and administered the dose on 12/19/25. Queried RN12 about the eight missed doses in January. RN12 said the medication was not available and was not administered. Queried RN12 if this information was communicated to the family and documented in the progress notes. RN12 searched the progress notes and was not able to find documentation that the family was notified to provide more of the medication.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interviews, the facility failed to maintain accurate medical records for Resident (R)7) in accordance with accepted professional standards and practices. The documented reason for R7's missed medication dose was not accurate. This deficient practice has the potential to affect medical care provided to all the residents in the facility. Findings include:Cross-reference to F684 - Quality of Care Review of intake #2719563 stated R7's family filed a grievance regarding multiple missed doses of a prescribed medication. The medication in question was being provided by the family. The facility stated in the report that the medication was put on hold by the attending physician on 01/05/26. Review of R7's Electronic Health Record (EHR) was conducted. The Medication Administration Record (MAR) for January showed that Eltrombopag Olamine (medication that boosts the production of a blood component to stop bleeding) was not administered from 01/05/26 to 01/14/26, a total of eight doses. Documented reason for the missed dose on 01/05/26 was coded as Hold/See Progress Notes. Review of physician's orders conducted and no order to hold the medication was found. Review of the progress note dated 01/05/26 stated, . Awaiting arrival of meds (medication) from family member. On 04/23/26 at 08:58 AM, an interview and concurrent record review was conducted with Registered Nurse (RN)12 at the nurses' station. Queried RN12 if there was an order to hold the medication for R7 on 01/05/26 as stated in the MAR and in the grievance investigation notes. RN12 reviewed the physician's orders in the EHR and confirmed that there was no order to hold the medication. Review of attending physician's notes that were scanned into the EHR was also reviewed and no documentation to hold the medication was found. On 04/23/25 at 11:53 AM, review of the physician orders and January MAR was conducted with the Administrator in the conference room. Administrator acknowledged that there was no order found in the EHR to hold the administration of Eltrombopag Olamine.