STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125026	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kuakini Geriatric Care, Inc	347 North Kuakini Street Honolulu, HI 96817

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review the facility failed to provide documentation that written notice of transfer or discharge was provided to the resident or resident's representative (RRP), a copy of the notice was sent to the Office of the State Long-Term Care Ombudsman, and documentation that written notice of bed-hold was provided to the resident or RRP for 5 of 6 residents (Resident (R) 2, R3, R4, R9, and R10) sampled for discharge process. This deficient practice has the potential to affect all residents needing to be transferred from the facility to the emergency room/hospital.Findings include: 1) On 06/10/26 at 02:13 PM, a review was conducted for 3 Resident charts (R4, R9, R10): R4 was sent to the Emergency Department (ED) on 02/25/26 and returned during the evening of 02/25/26. No documentation of a completed discharge/transfer and bed-hold notice was found in R4's electronic health record (EHR) or was able to be provided by the facility. On 02/26/26, R4 was again transferred to the ED. A facility form titled, Unplanned Discharge/Transfer Notice was reviewed and no documentation was found that written notice of transfer was provided to the RRP. No bed-hold notice was found in the EHR or able to be provided by the facility. R9 was sent to the ED on 05/02/26 and admitted to hospital. A facility form titled, Unplanned Discharge/Transfer Notice was reviewed and noted, Date Discharge Notice Given with a date of 05/03/26. However, documentation on how the written notice was provided to the RRP was not found or able to be provided by the facility. No documentation was found in the EHR or able to be provided by the facility that written bed-hold notice was provided to the RRP. R10 was sent the ED on 03/09/26 and admitted to the hospital. A facility form titled, Unplanned Discharge/Transfer Notice was reviewed and noted, Date Discharge Notice Given with a date of 03/09/26. However, documentation that written notice was provided to the RRP was not found or able to be provided by the facility. There was also no documentation that this form was sent to the Long-Term Care Ombudsman. No documentation was also found or able to be provided by the facility that written bed-hold notification was provided to the RRP. On 06/10/26 at 03:28 PM, the Director of Nursing (DON) was interviewed in the first-floor conference room. The DON stated that the Nurse who sends the resident to the ED should complete the Discharge/Transfer Notice and whichever Nurse calls the family/RRP regarding the transfer should ask about the bed-hold. The DON also stated the written notice for both the discharged /Transfer Notice and bed-hold notice is currently not being provided/sent to the resident or resident's RRP. 2) On 06/09/26 at 09:00 AM, record review of R3's EHR noted R3 was transferred to the ED on 05/15/26 for low blood pressure and hypoxia (a condition where the body's tissues do not get enough (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxygen). There was no written bed-hold and discharge/transfer notification given to R3 or the RRP. On 06/10/26 at 10:00 AM, requested from the Director of Nursing (DON) the written bed-hold and discharge notification given to R3 or the RRP. On 06/10/26 at 12:44 PM, DON confirmed that there was no written bed-hold or discharge notification given to R3 or the RRP. 3) On 06/09/26 at 09:00 AM, record review of R2's EHR noted that R2 was transferred to the ED on 02/16/26 for right lower quadrant pain and difficulty breathing. There was no written discharge notification given to R2 or the RRP. On 06/10/26 at 10:00 AM, requested from the DON the written discharge notification given to R2 or the RRP. On 06/10/26 at 12:44 AM, DON confirmed that there was no written discharge notification given to R2 or the RRP.

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(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 interviews and record reviews, the facility failed to document pertinent findings and interventions for 1 of 3 residents (Resident (R) 5) sampled for transfers to the emergency department (ED) due to abdominal pain. This deficient practice puts residents at risk for their needs not properly being identified and addressed. Findings Include:On 03/20/26 at 09:22 AM, the Department of Health, Office of Health Care Assurance (OHCA) received a complaint (intake #296005) from a family member (FM) 2 on behalf of R5. FM2 noted that R5 is a [AGE] year-old male who suffered a brain bleed and was admitted to the hospital on [DATE]. R5 was then transferred to the facility on [DATE] for rehabilitation. On 01/31/26, FM2 noted that R5 was complaining of severe stomachache, but the nurses thought it was just a bowel movement problem and just gave him medications. FM2 noted that R5 was in tears and kept begging to be sent to the Emergency Department (ED). R5 was sent to the ED on 02/01/26 where he was found to have pancreatitis and admitted . On 06/09/26 at 09:33 AM record review of R5's electronic health record (EHR) note that R5 was admitted to the facility on [DATE] at 02:25 PM and was not in any pain. At 06:19 PM, R5 complained of difficulty swallowing and could not eat dinner and was given medications for nausea. At 06:19 PM, Certified Nurse Assistant (CNA) reported to the charge nurse that R5 complained of difficulty swallowing and was noted to have vomited clear secretions and food particles and that R5 felt better after vomitus. There was no health note documented for the entire day on 01/31/26. Review of R5's medication and treatment administration record (MAR/TAR) noted that R5 was given Ondansetron (medication for nausea and vomiting) 4 mg (milligrams) at 02:27 AM, and 10:13 PM on 01/31/26. R5's pain level on 01/31/26 on the evening and night shift noted that he had mild pain, however, no Tylenol was given for the pain. There was no health note to indicate that R5 was experiencing any nausea, vomiting, or pain on 01/31/26 and why the Tylenol was not given. On 06/09/26 at 01:45 PM, interview with Director of Nursing (DON) confirmed that there should have been daily charting on R5 since he was a new admission and was not sure why this was missed. DON also stated that it is important to document significant findings and issues to identify if the residents are declining and for continuation of care purposes.On 06/10/26 at 09:20 AM, interview with Registered Nurse (RN) 14, confirmed that no health note was created on 01/31/26 for R5. RN14 agreed that R5's nausea, vomiting, and mild pain should have been documented and if medications given were effective. CN1 also noted that there should have been documentation of why the Tylenol was not given, i.e. R5 refused. RN14 also stated that for new admissions they are supposed to document and monitor residents for at least 72 hours and to chart any significant findings that happened during the shift. RN14 also stated if the RN assigned could not document, they should have relayed their findings to the Charge Nurse (CN) at the end of shift report and that the CNs would be the ones to document the information. RN14 admitted that sometimes the RNs are in a rush to go home and are sometimes busy on the floor with other residents that they forget to document. RN14 acknowledged that documenting and relaying pertinent information provides continuity of care. On 06/12/26 at 02:00 PM, interview with the Education Coordinator (EC) confirmed that all nurses have been trained to document head to toe assessments for newly admitted residents for at least 72 hours. EC also noted that the RNs should be documenting any change of condition, pertinent findings, and relaying it to the next shift. EC was not sure why there are documentation gaps but noted that there has been no audit to ensure documentation requirements are met. On 06/12/26 at 02:30 PM, review of the facility's Documentation Related to Resident Care policy, in the Policy Statement it notes, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial conditions, shall be documented in the resident's medical record. The medical records should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. In the Policy Interpretation and Implementation section, it reads, The following information is to be (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented in the resident medical record a. objective observations; d. changes in the resident's condition.7.Documentation of procedures and treatments will include care-specific details including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual (s) who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/treatment; d. how the resident tolerated the procedure/treatment; e. whether the resident refused the procedure/treatment; f. notification of family, physician or other staff, if indicated. In the Procedure section, it details, 3. In addition to the monthly charting, Kuakini Geriatric Care charts by exception meaning documentation is done whenever anything unexpected occurs for the resident. Documentation in the resident's progress notes should be completed in the following situations: a. there is a significant change in the resident's mental or physical condition, b. any indication of illness/injury.4. Documentation should also be completed for the following: c. SNF daily charting.

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F 0684 Level of Harm - 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 interview and record review, the facility failed to ensure that Resident (R) 9 received treatment and care in accordance with professional standards. This was evidenced by the failure to timely assess, treat, and notify the Medical Doctor (MD) 2 regarding R9's complaint of pain during repositioning in bed reported by facility staff on 04/27/26 night shift (11:00 PM - 07:30 AM) and 04/28/26 day shift (07:00 AM - 03:30 PM). This deficient practice had the potential of contributing to worsening injury to R9 as the resident was admitted to the hospital several days later for left hip fracture identified as injury of unknown source.Findings include:The Office of Health Care Assurance (OHCA) received a facility-reported incident (FRI) Intake #3004586 for R9, dated 05/02/26, documenting a left hip injury of unknown source. The State Agency (SA) entered the facility on 06/09/26 for an abbreviated survey where the FRI was investigated.R9 is an [AGE] year-old female with a most recent readmission date of 05/08/26 and diagnoses that included left hip hemiarthroplasty (partial hip replacement) on 05/04/26 and advanced Alzheimer's dementia. R9 required dependent care for all activities of daily living (ADLs) and speech was limited to a few words that are not clear (per 06/08/26 Medical Doctor (MD) 2 progress notes).On 06/10/26 at 08:00 AM a record review was done to investigate the facility's 05/02/26 report of left hip injury of unknown source.A nursing progress note found in the electronic health record (EHR) dated 05/02/26 at 03:17 PM documented, Staff noted resident grimacing when turn to right side.Notified MD.ordered left hip X ray. Another nursing progress note dated 05/03/26 at 12:44 AM stated, MD ordered to send resident to ER for acute left hip pain r/o [rule out] fracture.Resident was sent to ER at 2250 [10:50 PM]. R9 was admitted to the hospital on [DATE] and had left hip hemiarthroplasty on 05/04/26.The facility's investigation packet for the 05/02/26 incident contained lettergrams which was staff's written account/involvement regarding the incident. A statement at the top of the Lettergram forms stated, For inter-departmental communication only. A lettergram dated 05/12/26 written by Recreation Assistant (RA) 1 stated, During facetime call on 4/28/26 at 3pm, [Family Member (FM) 1] noticed his mom appeared to be physically different than during call two weeks prior. [FM1] remarked upon facial grimacing, clenched jaw, facial drooping.Throughout video call, [FM1] mentioned concerns re: pain. No documentation in R9's progress notes in the EHR regarding FM1's concerns, nursing assessment of R9 related to FM1's concerns, and notification to MD2 regarding R9's status was able to be found.A lettergram dated 05/13/26 written by Certified Nurse Aide (CNA) 33 who worked the 04/27/26 night shift [11:00 PM - 07:30 AM] stated, I was the one assigned with patient.while giving care I noticed that whenever I turn her.face is grimacing which is unusual with the patient. Notified RN [Registered Nurse (RN) 22] and CNA (day shift) [Certified Nurse Aide (CNA) 27] about the situation (28 April Tuesday AM).A lettergram dated 05/12/26 written by CNA27 stated, 4/28/26 Assigned to take care of [R9] AM shift. [Night shift CNA] endorsed pt was grimacing when I turned from left to right especially when you touched her hip. Last round pt need to be change her briefs pt still the same grimacing and loud whenever I turned. I notified my RN and [RN22] responded that MD was notified.No entry in R9's progress notes in the EHR could be found regarding CNA27 and CNA33's report of R9's pain, any assessment done by RN22, or any notification to the doctor regarding R9's complaint of pain. A review of R9's April 2026 Medication Administration Record (MAR) noted 0 (0 = no pain) documented for the night shift on 04/27/26 and day shift on 04/28/26 and there was no entry of any ordered as needed pain medicine being given on those dates. An MD2 note could not be found that documented being notified of R9's 04/27/26 and 04/28/26 complaint of pain.On 06/10/26 at 12:08 PM the Director of Nursing (DON) was interviewed in the first-floor conference room. The DON confirmed that there was no progress noted charted in the electronic health record regarding R9's pain reported by the CNAs working on 04/27/26 night shift and 04/28/26 day shift, and no note documented indicating that RN22 assessed R9 and notified MD2. The DON stated that R9 should have been put on alert charting to (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	monitor R9's pain status and defined alert charting as charting every shift for a 72-hour time frame. The DON also confirmed that R9's pain status was not documented from 04/27/26 to 05/01/26 and that any significant resident medical status/changes, information, discussions and follow-ups should always be charted in the electronic health record.A facility policy titled, Documentation Related to Resident Care with a revision date of 03/2023 stated, Policy Statement:.changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.3. In addition to monthly charting, [facility] charts by exception meaning documentation is done whenever anything unexpected occurs for the resident. Documentation in the resident's progress notes should be completed in the following situations: a. there is significant change in the resident's mental or physical condition. b. any indication of illness or injury.

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F 0689 Level of Harm - Minimal harm or potential for 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** Based on interview and record review, the facility failed to do a thorough investigation post-fall for 2 of 5 Residents (Resident (R) 4, R10) sampled. This deficient practice placed the residents at risk for further falls and injury.Findings include: 1) R10 is [AGE] year-old female admitted to the facility on [DATE] with diagnoses that include left femur fracture with repair on 12/28/25 and dementia. On 06/12/26 at 07:02 AM, a record review was done. A nurse's progress note dated 03/09/26 at 04:18 PM documented that R10 was found on the floor and was first seen by her daughter. R10 complained of left hip pain post-fall and Medical Doctor (MD) 1 was notified. R10 was sent to the emergency room and subsequently admitted to the hospital with a hip fracture. R10 was readmitted back to the facility on [DATE] after undergoing open reduction and intramedullary nailing of left femur (surgical procedure to treat long-bone fractures) and revision of the 12/2025 intramedullary nailing of the left intertrochanteric (top of the thigh bone) fracture. On 06/07/26 at 09:20 PM, R9 had another unwitnessed fall and was found on the floor on the right side of her bed. On 06/12/26 at 09:05 AM, Licensed Practical Nurse (LPN) 3 was interviewed at the 5th floor nurse's station. LPN3 stated that R10's baseline prior to fall incident on 03/09/26: Required assistance of one person for ADLs except for eating, which she could do independently, incontinent of bowel and bladder, primarily Korean speaking but could understand simple English words, was high risk for falls and had a bed alarm placed in her bed because she would attempt to dangle her legs on the edge of the bed. On 06/12/26 at 09:42 AM the Administrator and Director of Nursing were interviewed in the first-floor conference room. The DON presented a blank copy of the post fall investigation packet that contained: 1) Falls checklist, 2) Neurological flow sheet, 3) Post-fall Resident Assessment. The packet is used to determine the cause and circumstances of the fall, assess any injuries, communication to responsible party and MD, and identification of any new fall prevention interventions to prevent reoccurrence. The DON stated that the post-fall investigation packet for R10 could not be found. The Administrator stated that the investigation packet with the post-fall checklist and assessment along with any staff interviews/statements should have been completed. A facility policy titled, Fall Management Program with a date of 8/2018 stated, PROCEDURE.8) An incident report will be prepared by the person(s) knowledgeable about the incident. 9) A Post-Fall Resident Assessment/Staff Debriefing from will be completed and used to implement fall prevention interventions. A facility policy titled, Patient/Resident Event Management with an effective date of 07/2008 stated, 2. Event Reports will be reviewed and appropriate follow-up will be conducted in a timely manner. a.The respective management staff will conduct an investigation and take corrective action where appropriate to prevent reoccurrence. 2) R4 is a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of but not limited to left knee pain, unspecified fall, atrial fibrillation, and muscle weakness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/26 at 08:39 AM, record review of R4's EHR noted that R4 had multiple falls since admission. R4 fell on [DATE] at around 04:45 AM and was found sitting on the floor and R4 sustained a laceration to the back of the head. The second fall happened on 02/26/26 at 03:55 AM, where R4 was found lying on the floor. There was no initial fall risk assessment completed on admission and no fall risk assessment completed after the 01/13/26 fall event. There was also no event report completed for R4's 02/26/26 fall incident. On 06/12/26 at 09:30 AM, requested from the Director of Nursing (DON) the initial fall risk assessment completed on admission, the fall risk assessment completed after the 01/13/26 fall incident, and the event report completed for fall incident on 02/26/26. On 06/12/26 at 10:16 AM, DON confirmed that there was no initial fall risk assessment completed on admission, no fall risk assessment completed for the fall incident on 01/13/26, and no event report for R4's fall on the 02/26/26. DON acknowledged the importance of completing fall risks assessments and fall incident report as it's a means of assessing what transpired and what needs to be changed and revised in the plan of care. On 06/12/26 at 01:37 PM, review of the facility's Fall Management Program, with a date of 08/2018, in the Procedure section, it reads, 1. At the time of admission, a Fall Risk Assessment record will be completed.8. An incident report will be prepared by the person (s) knowledgeable about the incident.9. A Post-fall Resident Assessment/Staff Debriefing /Staff debriefing form will be completed and used to implement fall prevention interventions.