STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aloha Nursing & Rehab Centre	45-545 Kamehameha Highway Kaneohe, HI 96744

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to identify and plan in advance for the situation where one Resident (R)4, of one sampled, would have a predictable condition decline, in which health care decision-making would be needed to provide guidance to the direct care staff. Specifically, when R4 had a significant change of condition, clinical interventions where implemented, the Power of Attorney (POA) was notified in a timely manner for direction, but staff failed to immediately consult with the physician about the condition change. As a result of the lack of planning, there may have been a delay in transfer to a higher level of care. Findings include: 1) R4 was a [AGE] year old male, who was a long term resident at the facility with a history of Parkinson's Disease, dementia, severe dysphagia (difficulty swallowing), coronary artery disease, chronic obstructive pulmonary disease, asthma, hypertension, and congestive heart failure. On 03/03/2025, R4 was sent to the hospital due to shortness of breath, and poor oral intake, where he was diagnosed with aspiration pneumonia (lung infection that occurs when food, or vomit is inhaled into the lung instead of being swallowed). R4 was transferred back to the facility on [DATE]. On return, R4 remained a high risk for aspiration. On 04/06/2025, R4 was found to have unstable vital signs and transferred to the hospital again for a higher level of care. He was admitted to the intensive care unit with acute hypoxic respiratory distress, aspiration pnuemonitis and sepsis, where he deteriorated and passed on 04/07/2025. 2) Review of R4's medical records revealed the following: R4 had an Advanced Health Care Directive (AHCD) he signed on 09/08/2017. His wishes were documented to be as follows: - 1 A. Choice not to prolong life if: I have an incurable and irreversible condition that will result in my death within a relatively short period of time, OR I become unconscious and, to a reasonable degree of medical certainly, I will not regain consciousness, OR The likely risks and burdens of treatment would outweigh the expected benefits. - I do want artificial Nutrition and Hydration regardless of my condition and regardless of the choice I have made in question 1A/B. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R4 designated his daughter to be his agent to make health care decisions for him (POA/power of attorney) at that time, which became effective when he was no longer to make his own decisions. R4 did not have a Hawaii Provider Order for Life-Sustaining Treatment (POLST). The POLST is a medical order, that Emergency Medical Services follow when called to transfer a resident. It is not an Advanced Directive and is not intended to replace one. R4's Care Plan for Advanced Directives last revised 07/30/2024 included Resident's Advanced Directives Wishes Will Be Known With DNAR (do not attempt resuscitation/DNR) status.Licensed staff will honor resident's wishes regarding resuscitation, instituting only comfort/dignity measures in the event resident has no pulse and no breathing. Reviewed the facility policy titled Advance Directives, revision date 04/17/2025. The policy included: Policy: It is the policy of this facility to recognize the right of an adult to make decisions regarding his/her medical care, including the right to accept or refuse treatment. The facility supports a resident's right to execute Advance Directives, including a Living will, a Durable Power of Attorney for Health Care and a Legal Surrogate for Health Care. Reviewed the last two letters the facility provided to R4's POA on a quarterly basis, to document if there are any changes they would like to make to the existing Advanced Heath Care Directive. Both letters were checked by the POA that she did not want to make any changes. There was no discussion of AHCD, POLST or situations that might occur in the Interdisciplinary Team notes. 3) Reviewed R4's Speech evaluations, which included the following: 03/11/2025 Assessment summary: .Patient requires extensive assistance and cueing to safely tolerate a small amount of PO (oral) for adequate nutrition/hydration. Patient exhibits increased difficulty managing honey thickened liquids, therefore if pleasure feeding is initiated, this ST (speech therapist) recommends the patient consume nectar liquids.In limited amounts, patient may tolerate puree solids and nectar liquids for pleasure, however, it is imperative for caregiver to utilize strategies consistently and or the entirety of PO intake, otherwise potential for aspiration is high.patient is not safe to consume PO by mouth to maintain adequate hydration /nutrition . 03/24/2025: Pt severe risk for asp PNA (aspiration pneumonia), MPOA (medical power of attorney) wishes pt. (R4) to remain PO despite NPO (nothing by mouth) recommendations . 03/26/2025: Precautions/Contraindications: Diet: puree/pudding for oral gratification/comfort feeding ONLY. Pt must be fed by trained caregiver. High aspiration risk. Strategies do not eliminate risk for aspiration. PO is for comfort only at the request of daughter.with dedicated feeder. The POA hired caregivers to feed R4, who were trained strategies to feed him. 4) Reviewed Provider (MD1) visit notes dated 04/02/2025. The notes revealed the following entries: - Pneumonia: continues to be high risk for aspiration. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- Dysphasia: failed swallow evaluation, continued discussion with daughter regarding high risk for patient to aspirate with any consistency, still does want not PEG (feeding tube inserted through abdominal wall used for nutrition) and also encouraged her that it does not line up with his wishes. - Severe protein-caloric malnutrition: intake is poor, continue one on one support during meals 5) Nursing Progress Note 04/06/2025, entered at 05:16 PM: Resident was fed by caregiver (private paid caregiver) pudding think [sic] liquids starting at 09:30 (AM) until 1300 (01:00 PM) including breakfast, snack and lunch. Daughter called caregiver and spoke to her while she was with the resident. Resident's lungs and heart were checked after feeding per orders. The [sic] was no coughing noted, lung sounds were diminished in both lower lobes. Resident's private care giver left at 13:30 (01:30 PM). He (P4) stayed in his chair in the hallway in view of nurse until he was put in bed around 14:00 (02:00 PM). At 15:20 (03:20 PM) vitals: BP 58/33, pulse 90, SaO2 (oxygen saturation) 83% on 3 liters nasal cannula. A nebulizer treatment (device used for respiratory conditions that turns liquid medication into fine mist inhaled into the lungs) was given at 15:30 (03:30 PM). At 15:34 (03:34 PM) family was called to inform of change in condition. A message was left. Supervisor informed at 15:45 (03:45 PM) and MD1 was called around 16:00 (04:00 PM) and message left on his phone. Nasal cannula was switched to mask on 10 liters per min (minute) at 1550 (03:50 PM). 911 was called and arrived at 04:45 PM and left for hospital at 1700 (05:00 PM). 6) On 05/30/2025 at 12:30 PM, interviewed the House Supervisor (HS) about her involvement on 04/06/2025. She said the Nurse (RN1) called and informed her R4 was not stable. She said she went to assess him, and asked RN1 if she reached out to daughter, which she had already done. The HS said R4's Code Status was DNR and they wanted to make sure the POA wanted to transfer him to the ER. She said when she arrived to the room, RN1 was in the process of giving a nebulizer treatment. The HS said vitals were rechecked and he had 74 systolic with 83% on cannula. He seemed comfortable, was looking at me and tracking, but nonverbal. She said she spoke with the POA on the phone and wanted to get a decision to send R4 to ER, or not. The HS told the POA that there were no other interventions that could be done at the facility, and needed to know if she wanted him to go to the hospital. At that time, the POA said to send him out. The HS called EMS immediately, who had an arrival time of about 20 minutes. She said R4 was still alert when he left the facility. On 05/30/2025 at approximately 02:00 PM, conducted a telephone interview with RN1. She said R4 had several trips to the hospital and had shown significant decline. She said the POA was actively involved in his care and they would call her with any condition change. She went on to say that day, he stayed up about 30 minutes after lunch and around 02:00-03:00 PM, R4 was lying in bed when one of the CNA's came out of room, and said his vitals weren't good. RN1 said she went in, assessed him and immediately gave a nebulizer treatment around 03:00-03:20 PM. She said that she can increase the oxygen to 5L. RN1 said she called the POA and a left message about R4's vital signs. She said when she did call back, the POA was very upset and difficult to get her to understand she was trying to get clarification to send him to the hospital or not. The POA told her to call MD1, so she left a message. RN1 said at some point, the HS called 911. RN1 explained she was confident calling 911 without an MD order, but in this case, she wanted to have the conversation with the POA and I wanted to fulfill everyone's wishes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 05/30/2025 at 03:15 PM, interviewed the Director of Nursing (DON) in the conference room. She said the facility reviewed what happened that day, and she felt confident in the decisions the staff made. The DON said the CNA called for help, they found his O2 dropped, and staff intervened by elevating the head of bed, gave nebulizer treatment and additional oxygen. The House Supervisor was notified and they reached out to POA and MD, to plan for what to do next, discuss whether to send him to the hospital or not. They were waiting to get directive from her. On 06/06/2025 at 09:15 AM conducted a phone interview with MD1. He said he had multiple discussions with R4's POA about what to do should her father have a condition change. It was his suggestion to keep him at the facility and care for him there, rather than transfer to the hospital. He went on to say the Resident was a DNR and she did not want any nutritional support or CPR. MD1 said the POA said that the last time R4 went to the ER, he had to wait in the ER for 9 hours and she did not want to happen again. She wanted to be called with any update regarding her father's condition and wanted to keep her right to make the decision then to transfer him or not. MD1 said the POA wanted to arrange for a direct admission rather than go to the ER if something happened, and that he had explained should there be a condition change, the decision to transfer would need to be timely and would likely not allow for arrangements such as that to be made. He also explained her father's condition may need interventions on arrival to the ER and direct admission would not be best in that situation. He said she wanted to avoid the ER, but didn't want to give up the right to make the decision to go to the hospital, or not. Inquired if the nursing staff were aware of the POA's feelings, and he said yes. 7) Reviewed the facility policy titled Emergency Care of Residents, revision date 04/17/2025. The policy included: Policy: It is the policy of this facility to provide or arrange for appropriate medical care and other professional services for each resident when emergency care is needed. 1. Complete an initial assessment, i.e., head to toe assessment, checking for obvious injuries and taking vital signs. Note: Nursing Services staff are trained to do appropriate resident assessment prior to contacting the physician. 3. Notify the Charge Nurse as soon as possible. Nurses are expected to use clinical judgement skills (or consult with Charge Nurse) in deciding if an event is a medical emergency. 4. Seek a physician's assistance as indicated by the type and severity of the emergency. 5. If required, arrange for transport to the Emergency Room. If an ambulance is called, refer to the policy and procedure entitled, Emergency Procedure for 911 Calls. 6. Contact the resident's responsible party .as needed. 7. Document pertinent information in the Nurses' Notes. Reviewed the facility policy titled Emergency Procedure for 911 Calls, revision date 04/17/2025. The policy included: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Policy: It is the policy of this facility to activate the Emergency Medical Services (EMS) ambulance system by calling 911 when indicated. 1. Staff personnel will call 911 with a directive from a physician, or conditions warranting assistance from emergency personnel and transport to an acute facility. Such conditions include discovery of a resident who is unconscious and has a physicians order for Cardiopulmonary Resuscitation (CPR). Reviewed the facility policy titled Oxygen Therapy, revision date 04/17/2025. The policy included: Purpose: The purpose of this policy is to establish responsibilities for the care and use of oxygen therapy. Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a MD/APRN, except in case of an emergency. In such case, an emergency oxygen order can be initiated that states: In an event where the resident's oxygen level decreases below 90% and requires supplemental oxygen, may initiate O2 via nasal cannula at 0-3 L (liters per minutes), then attempt to wean. If a resident is unstable, requires additional oxygen above 3L, MD/APRN will be notified immediately. 8. Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen. 8) R4 had a AHCD and a designated agent/POA, who was clear that she did not want tube feedings and understood he was at high risk of aspiration. R4 was DNR for the clinical situation of no pulse or respirations. MD1 had discussions with the POA, who felt strongly she wanted to be notified of any condition change and keep the right to determine to transfer to the ER or not. It was explained to her timeliness could be an issue. These interactions and discussions did not occur in the IDT and there was no further planning to provide guidance to the staff how to respond to a predictable situation. In addition, there was no discussion about the importance of a POLST in this situation, to ensure the POA understood if R4 had respiratory or cardiac arrest during transport, CPR would occur which she did not want.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record and document review, the facility failed to make timely revisions to the comprehensive person-centered care plan of four residents (R)1, R2, R3 and R4, of six residents sampled. Findings include: 1) R1 was a male admitted to the facility on [DATE] for pneumonia, due to Coronavirus. He required one person assist for all activities of daily living. On 09/09/2024, a family member (FM)1 made a complaint regarding nursing care, and specifically requested that R1's clothes be changed daily, and that he would be up for all meals. Review of the complaint/grievance form included the follow up .(Director of Nursing/DON) to f/u w/CNA's (follow up with Certified Nurse Assistants) about standard of care-specifically changing Res' (R1's) clothes daily. Res will be up for all meals. The document indicated the issue was resolved. Review of Nursing Progress notes dated 09/25/2024 at 10:57 AM revealed the following entry: .Requires 1x person mod (moderate) assist with ADL's and transfers.Requires 1:1 Feeding Assistance. Review of R1's care plan (CP), revealed it was initiated on 08/08/2024, but there were no revisions to the CP to reflect the preferences of care agreed on in the grievance. In addition, the CP did not include R1's need for 1:1 feeding and one person assist for ADL's and transfers. On 05/30/2025 at 03:15 PM during an interview with the DON in the conference room, she said although there was verbal follow through with the staff, the CP should have been revised. 2) R2 was a [AGE] year old male admitted to the facility on [DATE] for services related to Metabolic Encephalopathy (condition characterized by systemic metabolic disturbances). R2 uses oxygen due to hypoxic respiratory failure (insufficient oxygen in the blood) and aspiration pneumonia, congestive heart failure and chronic obstructive pulmonary disease. Reviewed R2's orders, which included EMERGENCY O2 (oxygen) ORDER: In the event of an emergency where the resident's oxygen decreases below 90% and requires supplemental oxygen, may initiate O2 via nasal cannula at 0-3L (liters), . Reviewed R2's active CP, which revealed the following intervention: EMERGENCY O2 ORDER: In the event of an emergency where the resident's oxygen level decreases below 90% and requires supplemental oxygen, may initiate O2 via nasal cannula at 0-3L or simple mask, then attempt to wean. The CP did not reflect the actual order. 3) R3 was a [AGE] year old male was admitted to the facility on [DATE] after being hospitalized for respiratory failure. He had a history that included heart failure, hypertension, diabetes type 2, and carcinoma of the tongue. R3 needed assistance with activities of daily living and transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/28/2025 at 04:45 PM, R3 was found on the floor in his room after attempting to get out of bed. Reviewed the Fall Report #1160, which revealed after the fall, floor mats were ordered for safety. On 02/28/2025 at 07:20 PM, R3 was found sitting on the floor. The immediate action included: .Ordered floor mats for safety. R3 was transferred to the hospital for further evaluation and admitted . On 03/03/2025, R3 was readmitted to the facility after hospitalization with a terminal prognosis and hospice services, related to his metabolic encephalopathy and failure to thrive. On 03/06/2025, R3 had an additional unwitnessed fall on 03/06/2025. The fall report included Resident .was found on the floor mat . Reviewed R3's CP, which revealed the initial CP developed on 02/21/2025, included the following fall interventions: - Be sure call light is within reach and encourage the resident to use it for assistance as needed. the resident needs prompt response to all requests for assistance. - Encourage resident to OOB (out of bed) and engage in meals. activities. - Ensure that the resident is wearing appropriate footwear non-skid when ambulating or mobilizing in w/c. - Follow facility Fall Prevention protocol. - Frequent rounding to assess needs, offering toilet and reposition. The CP was not revised after the three falls to include the mats, or other interventions to help prevent more. 4) R4 was a [AGE] year old long term resident at the facility. He had a medical history that included Parkinsons Disease, aspiration pneumonia, dementia, severe dysphagia (difficulty swallowing), chronic obstructive pulmonary disease, asthma, hypertension, and congestive heart failure. R4 requires supplemental oxygen at times for shortness of breath. Reviewed R4's medical records which revealed the following: Physician order dated 03/22/2025: May administer supplemental oxygen via nasal cannula at 0-3 Liter/minute, in order to keep oxygen saturation >92%, wean when tolerated. Review R4's CP, intervention initiated on 02/12/2025 for respiratory issue included: EMERGENCY O2 ORDER: In the event of an emergency where the resident's oxygen level decreases below 90% and requires supplemental oxygen, may initiate O2 via nasal cannula at 0-3L or simple mask at 0-3L, then attempt to wean. The CP does not accurately reflect the order. Nursing Progress note dated 04/05/2025 01:22 PM: Resident is being monitored for Stage 3 pressure injury to left lateral floor. Heel boots on when in bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's CP identified R4 had a Deep Tissue Injury to the left lateral foot, but the CP had not been revised to include the current condition of the now Stage 3 wound, or the preventive heel boots. Due to R4's severe dysphasia and high risk of aspiration, he required 1:1 monitoring for meals and had hired caregivers to feed him. The CP related to nutrition was last revised 03/13/2025 to reflect he was NPO (nothing by mouth), which was not accurate. On 04/03/2025 there was a dietary order Pureed texture, Pudding Thick consistency, Pleasure feeding . 5) On 05/30/2025 at 03:15 PM. during an interview with the DON in the conference room, reviewed the care plans of R1, R2, and R3. She agreed the CP's had not been revised to reflect current orders and interventions.