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	08/01/2025

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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interviews, and review of the facility's Feeding Impaired Resident's policy, the facility failed to promote care that maintains the dignity for one out of seven residents (Resident (R) 57) observed during dining observation. This deficient practice has the potential to affect all residents who require assistance with their meals.Findings Include:On 07/29/25 at 12:30 PM, observed R57 in bed waiting for assistance with lunch. At 12:35 PM, Certified Nurse Aide (CNA) 41 came into R57's room to assist R57 with lunch. Observed CNA41 assisting R57 with four to five spoonful of food and sips of juice while standing up. At 12:40 PM, observed CNA41 taking the lunch tray away. CNA41 did not take time to encourage resident to eat more and only spent five minutes assisting R57 with lunch.On 07/29/25 at 12:45 PM, interview with CNA41 stated the facility's policy for assisting impaired residents with their meals is to be sitting down. CNA41 stated sitting down while assisting the residents with their meals would make them feel more comfortable. CNA41 also verbalized that R57 does not eat that much and requires a lot of encouraging. On 07/29/25 at 12:50 PM, interview with Registered Nurse (RN) 66 confirmed CNAs should be sitting down when assisting resident with meals so that residents do not feel intimidated and residents should be allowed enough time to eat as much as possible and agreed that five minutes was not enough time.On 08/01/25 at 01:30 PM, review of the facility's Feeding Impaired Residents policy, with revised date of 04/17/25, in the Procedure section, it notes, 7. Allow the resident plenty time to eat and chew his/her food. Do not rush the resident. Talk with the resident as he/she eats. Be pleasant. Do not give the resident the impression that you are in a hurry.18. Continue assisting until the resident has had enough food or until the meal is finished. In the Steps in the Procedure section, it notes, 8. If you are going to be seated during the meal, position a chair where it will be convenient for you and the resident.20. Assist the resident slowly. Allow plenty of time between mouthfuls.

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

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	08/01/2025

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

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to discuss and complete the baseline care plan (BCP) within 48 hours for one out of one residents (Resident (R) 28) sampled for BCPs. This deficient practice places residents at risk for not receiving appropriate and timely care, delays the development of care to address resident's immediate health and safety needs, hinders continuity of care, and impedes communication amongst nursing staff. Findings Include:On 07/30/25 at 09:29 AM, interview with R28 noted that the facility did not include him in care plan decision making when he first was admitted . On 07/31/25 at 3:00 PM, record review of R28's Electronic Health Record (EHR) noted he was admitted to the facility on [DATE]. No BCP found in the EHR and no documentation that BCP was discussed with R28 or Family Member (FM) within 48 hours of admission. On 8/01/25 at 08:45 AM, interview with Director of Nursing (DON) noted the facility will discuss the care plan conference summary and med orders with resident and family upon admission and will give them a copy of it. DON confirmed that the discussion took place on 07/22/25 and it was delayed (delayed by 13 days). DON also confirmed that there was no other documentation that a BCP was given sooner than 07/22/25. DON confirmed that BCPs are important to be reviewed and completed timely for both resident and family as it provides additional input to know and what to expect in a new environment. On 08/01/25 at 01:30 PM, review of the facility's Baseline Care Plans policy, with a revised date of 04/17/25, in the Policy Explanation and Compliance Guidelines section, it notes, 1. The baseline care plan will be developed within 48 hours of a resident's admission.3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed.

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	08/01/2025

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

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that one of two residents (Resident (R) 2), sampled for limited range of motion (ROM), received the appropriate treatment to prevent or delay a further decrease to the contracted lower extremities. This hindered R2's ability to maintain the highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility who have limited ROM.Findings Include:Resident (R) 2 is a [AGE] year-old male admitted to the facility on [DATE] for long term care with a primary diagnosis of anoxic brain damage (brain loses oxygen supply causing permanent brain damage). A Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/02/25 noted R2 requires dependent care (resident does none of the effort to complete the activity) for his Activities of Daily Living (ADL) and for rolling left and right in bed. On 08/01/25 at 08:07 AM, a review of R2's care plan was conducted. The Focus section of R2's ADL care plan documented, He is noted with contractures to BLE (Bilateral lower extremities) with a revision date of 07/10/25. The Intervention section of this care plan listed, Apply black LE (lower extremity) positioning device in bed and Geri chair.Apply Left knee comfy splint daily. Both interventions listed 07/11/25 as the initiation date. R2's Wound Management care plan stated, Heel boots in place with an initiation date of 07/14/25. On 08/01/25 at 09:05 AM, interviewed Certified Nurse Aide (CNA) 80 in R2's room. CNA80 stated R2 should have a left knee splint and a positioning cushion between his legs to help with his contractures. CNA80 was unable to locate both items and stated she was then going to check with the laundry department if the cushion for his legs was being washed.On 08/01/25 at 09:18 AM, CNA80 brought up the positioning cushion from the laundry department but stated the left knee splint was missing. CNA80 stated she checked with Physical Therapist (PT) 1, and a new one was going to be ordered. On 08/01/25 at 09:43 AM, interviewed PT1 in the therapy department. PT1 confirmed R2's left knee splint was missing, last recalled seeing it on 07/11/25, and will be ordering a new one. On 08/01/25 at 09:21 AM, observed CNA14, CNA18, and CNA80 assisting R2 with incontinence care and positioning. CNA80 first applied one blue and then one black cover over the positioning cushion and confirmed this was R2's black LE positioning device. CNA80 was able to locate only one heel boot. All three CNAs stated they were unsure if R2 is supposed to have two heel boots. On 08/01/25 at 09:25 AM, CNA18, who was assigned to care for R2 for the shift, stated she was not sure how to apply the positioning cushion because she had not worked with R2 for a long time. CNA14 stated that they are informed about R2's left knee splint, positioning cushion, and heel boots through the shift report sheet. However, upon review of the shift report sheet, the heel boots were not listed. On 08/01/25 at 09:55 AM, Unit Manager (UM) 2 confirmed that the heel boots should have been listed on the shift report.On 08/01/25 at 10:20 AM, interviewed the Resident Care Coordinator (RCC) 2. RCC2 confirmed that R2's left knee splint was missing since 07/11/25. A concurrent review of the Point of Care (POC) screen where CNAs document their tasks and located in the Electronic Health Record (EHR) was marked as done. A sample audit of dates (07/11/25, 07/12/25, 07/14/25, 07/18/25, 07/28/25, and 07/31/25) for the application of the left knee splint were reviewed, and all were signed off as being applied. However, the splint was missing during those dates. RCC2 confirmed that the CNAs should not have signed off for the left knee splint application since it was missing. RCC2 also stated that the CNAs were responsible for applying R2's left knee splint, LE positioning device, and heel boots. RCC2 confirmed R2 should have two heel boots applied and confirmed that both the LE positioning device and heel boots were not listed on the POC for the CNAs to sign off the application of that equipment.

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	08/01/2025

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

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 - 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. Based on observations, interviews and record reviews, the facility failed to implement interventions to prevent avoidable falls for one of one (Resident (R)19) sampled. R19 had fall five fall incidents from 05/11, 06/01, 06/10, 06/17, and 07/17/25. One of the five fall incidents resulted with R19 sustaining an arm injury (abrasion or skin tear).Findings Include: On 07/29/25 at 09:16 AM, during a tour of the facility, observed R19's room was located farthest from the nurses' station and with door completely closed. After knocking and requesting permission to enter R19's room, seen him alone, sitting at the right side of the bed eating breakfast.Reviewed the facility matrix on 07/29/25 at 10:30 AM. Noted R19 with Alzheimer's/Dementia or a syndrome characterized by progressive decline in cognitive functions, such as memory, thinking, reasoning, language, and judgment, that interferes with daily life and independence, and a fall with injury. On 07/30/25 at 11:17 AM, Electronic Medical Record (EMR) review was done. Noted nursing staff implemented neuro-checks with R19 after a fall incident on 07/17/25. Minimum Data Set (MDS) quarterly review dated 07/22/25, Brief Interview for Mental Status (BIMS) summary score of 99, indicating unable to complete the interview. Under functional abilities and goals under section GG-Mobility noted devices included walker and wheelchair. Under self-care section, with R19's toileting, indicated set-up or clean-up assistance. Under mobility, noted R19 requiring supervision. Comprehensive care plan noted the resident is at risk for injury and/or falls. R19 is noted with incontinence, impaired gait, and poor safety awareness. Revision on 06/10/25 noted with interventions to .continue with all interventions in place to reduce risk of injury. Revision on 06/17/25 was done with interventions instructing staff to .encourage resident to leave the door open for increased supervision. On 07/30/25 at 10:15 AM, concurrent observation and interview was done with Registered Nurse (RN) 20. When asked if staff always closes resident's door, RN20 confirmed that they always made sure that R19's door was closed. RN20 also added that staff honor the resident's choice. On 07/31/25 at 02:21 PM, an interview was done with the Director of Nursing (DON) in the training room. When asked if R19's care plan was updated to include a goal for fall prevention, DON confirmed that following R19's fall incidents, the facility did not assess factors contributing falls and did not update care plan accordingly to include routine visual checks to reduce potential for further falls and/or injury. On 07/31/25, reviewed facility policy titled Falls: Post Fall Guidelines directs the facility, . that timely and appropriate assessment, monitoring.Licensed nurse will monitor the resident.more frequently if indicated .will be completed following a resident's fall.to provide care, to reduce the potential for further falls and/or minimize resident's injury.

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	08/01/2025

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

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, interviews, and record review, the facility failed to provide care and services to prevent dehydration for one (Resident (R) 21) of one resident in the sample, despite identifying them as at risk for compromised nutrition and hydration. This deficient practice could affect residents who rely on staff to provide fluids to them throughout the day to maintain proper hydration and health.Findings Include:On 07/29/25 at 09:15 AM, concurrent observation and interview was done. Observed no water pitcher found in R115's bedside. Subsequent observation was done at 10:35 AM and found no water pitcher was provided at resident's bedside. An interview was done at 11:00 AM with Certified Nurse Aide (CNA135) inside resident's room if R115 requires a water pitcher inside her room and she confirmed that resident is able to pour water from a pitcher and should have water pitcher at bedside.On 07/30/25, review of R115's Electronic Health Record (EHR) found her diagnoses included, but are not limited to, Cerebral infarction or death of brain tissue due to a lack of blood supply, Hemiplegia and Hemiparesis or medical conditions that cause weakness or paralysis on one side of the body. During this review, found R115's care plan with date of initiation on 07/18/25, stated that resident is at risk for fluid and nutritional imbalance. Hydration/Nutrition note with initiation date of 07/29/25, instructed staff to monitor R115's estimated daily nutrition and hydration needs between 1615 ml - 1940 ml fluids per day. Bladder/Incontinence included interventions for staff to encourage fluids during the day to promote prompting voiding responses. On 07/31/25 at 02:25 PM, an interview was done with the Director of Nursing (DON) in the training room. When asked if R115 should have water pitcher at her bedside. The DON confirmed that R115 should have been provided with water picture at bedside. The facility's policy and procedure titled, Fluid Intake: Hydration Program, with a revision date of 04/17/25, stated that, . Additional fluids are routinely available via pitchers of water at bedside.

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	08/01/2025

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

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have a protocol to identify past trauma experienced for two of two residents (Resident (R) 3 and R40) sampled for mood/behavior. As a result of this deficient practice, both residents did not have their trauma triggers identified, placing them at increased risk of re-traumatization, and was hindered from attaining their highest practicable mental and psychosocial well-being.Findings Include:1) R3 is a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses that include vascular dementia, with other behavioral disturbance and post-traumatic stress disorder (PTSD). A Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/12/25 noted that R3's Brief Interview for Mental Status (BIMS) score of 03, which indicated that R3 has severe cognitive impairment. On 07/30/25 at 08:45 AM, interviewed R3's Family Member (FM10). When asked about past trauma in R3's life, FM10 stated that R3 was in the Vietnam War and has a diagnosis of PTSD. FM10 stated there was one incident in the past when R3 and his wife went to a war movie that caused a negative reaction and caused him to try and hide under the seat.On 08/01/25 at 06:45 AM, a review of the records was conducted for R3. No TIC assessments were able to be found. 2) R40 is a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses that include unspecified dementia and post-traumatic stress disorder. A Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/18/25 noted that R40 had a Brief Interview for Mental Status (BIMS) score of 01, which indicated that R40 has severe cognitive impairment.On 07/30/25 at 06:31 AM, a review of the records was conducted for R40. No TIC assessments were able to be found. A review of the facility's policy titled, Quality of Care -Trauma Informed Care stated, Organizational strategies.6. Implement screening of residents for trauma .Resident-Care Strategies 1. As part of the comprehensive assessment, identify history of trauma or interpersonal violence.may involve record review or the use of screening tools.On 08/01/25 at 10:00 AM, interviewed Social Services (SS) 2 in the conference room. SS2 was asked how the facility attempts to identify past trauma and triggers that may be stressors for a resident diagnosed with PTSD and if a trauma screening was done on admission for R3 and R40. SS2 stated there was no process in place to conduct a TIC assessment if a resident is admitted with a diagnosis of PTSD, but it should be done. SS2 stated there is no trauma screen or assessment form that is utilized. SS2 stated that she was unable to look if a TIC assessment was completed on initial admission for R3 and R40 because the current Electronic Health Record (EHR) did not contain information for both residents' initial admission dates (07/10/18 for R3 and 02/25/21 for R40). No TIC assessment documents from the current EHR system were provided.

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	08/01/2025

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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that medications and equipment in two of three medication carts and wound care supplies for one resident (Resident (R) 9) were stored and labeled in accordance with professional standards. Proper storage and labeling of medications and equipment are necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility who take medications and utilize equipment stored in the medication and treatment carts. Findings Include: 1) On [DATE] at 09:44 AM, a medication cup containing a white cream and tongue depressor was observed at the bedside of Resident (R) 9. At 09:47 AM, interviewed Registered Nurse (RN) 75 inside R9's room. RN75 stated that the white cream was Flagyl powder that was mixed with the cream and applied to R9's coccyx wound by the evening shift nurse. RN75 confirmed that it should not have been left by the bedside unattended and should have been discarded. 2) On [DATE] at 09:47 AM, an unlabeled bottle of Dakin's solution and unlabeled tube of Hydrogel was observed in a box placed in R9's nightstand. On [DATE] at 09:00 AM, interviewed RN75 regarding the bottle of Dakin's solution and tube of Hydrogel which was now located on R9's bedside table. RN75 stated the Dakin's solution and Hydrogel tube were provided by Hospice and were currently being used for R9's wound care. RN75 stated both items should have been labeled with R9's name, room number, and stored in the locked treatment cart. On [DATE] at 09:15 AM, interviewed the Director of Nursing (DON) in R9's room. The bottle of Dakin's solution and tube of Hydrogel remained on R9's bedside table. DON confirmed no matter who supplies the wound care treatments and medications (e.g. hospice, family, pharmacy), all should be labeled with at least the resident's names and locked in the unit's treatment cart when not in use. 3) On [DATE] at 07:57 AM, observed RN75 preparing medications. When RN75 left the medication cart and went into a resident's room, observed a medication cup with crushed medications was left on the medication cart under a stack of drinking cups. The medication cup was labeled with R108's name. At 08:04 AM, interviewed R75 upon returning to the medication cart. RN75 confirmed that the medication cup with the crushed medications should have been placed in the medication drawer and locked up before leaving the cart. RN75 stated the medicine cup contained Tylenol 500mg 2 tablets and Senna Plus 8.6-50mg 2 tablets. A facility policy titled, “MEDICATIONS: STORAGE”, with a revision date of [DATE], noted “1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments…d. The facility will ensure that all drugs and biologicals used will be labeled in accordance with professional standards…” 4) On [DATE] at 08:51 AM during a medication cart observation with Registered Nurse (RN) 15 observed three residents (R) 97, R113, and R117 eye drops did not have the open on and discard by date. Inquired of RN15 if the eye drops should have had the opened on and discard by dates written on them and RN15 confirmed these dates were missing and should have been written on the label when the eye drops were opened. (continued on next page)

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	08/01/2025

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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5) On [DATE] at 08:58 AM an observation of a medication cart with RN15 was made of the glucometer control solutions that were expired, labeled as opened on [DATE] with a discard date written on the box of [DATE]. This was the only control solution observed in the medication cart near the blood glucose testing machine. Inquired of RN15 if the control solution should have been discarded and RN15 confirmed the control solution should have been thrown away when it expired on [DATE].

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	08/01/2025

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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based observation, interviews and review of the facility's Food Management System policies, the facility failed to monitor and check the dishwasher sanitizing temperature logs on a consistent basis, properly label open food items in the freezer, and discard food items in the refrigerator by its use-by date. This deficient practice places residents in the facility who are provided with meals, at risk for foodborne illness.Findings Include:1) On 07/29/25 at 08:00 AM, initial walkthrough of the kitchen with Kitchen Staff (KS) 1, noted dishwasher heat sanitizing log with missing temperature checks for the following dates and mealtimes for the month of July:07/08-07/29, missing dinner check07/11-07/20, missing breakfast check07/25-07/27, missing breakfast check07/27, miss lunch checkConcurrent interview with KS2 noted the missed documentation and she forgot to check temperature on some of those days. Both KS1 and KS2 confirmed that the dishwasher sanitizing temperature should be checked three times a day, every day when washing dirty dishes after each meal to ensure dishes and utensils are being sanitized appropriately before being reused. 2) Observed in refrigerator, a storage container bin with tomato pastes with use-by date of 07/27/25, a container of ham with use-by date of 07/23/25, and a container of green leaf lettuce with use-by date of 07/26/25 still in the refrigerator. Concurrent interview with K2 noted that staff forgot to check the refrigerator and throw out food that were past the use-by date. K2 noted that foods should be discarded by the use-by date to ensure that foods being served to residents are not spoiled and to prevent foodborne illness.3) Observed in freezer, an open bag of carrots and open bag of boiled eggs without any labels of when it was first used. K2 noted that staff forgot to label the items with an open and use-by date. K2 confirmed that properly labeling food items helps to identify the use-by date and to keep old food from being served to residents. On 07/30/25 at 01:30 PM, interview with Dietary Manager (DM) confirmed that the dishwashing sanitization logs should be checked three times a day to ensure that dishes and utensils are being thoroughly cleaned, and that no transmission of bacteria occurs. DM stated he has not been able to review the logs for missing entries as they have been short. DM stated there are days where he and his cooks are being pulled to complete other duties. DM also noted that opened items in both the refrigerator and freezer should be labeled appropriately with open and discard date, and food items to be discarded by the use-by date to prevent foodborne illness. On 08/01/25 at 01:30 PM, review of the facility's Low Temperature Mechanical Warewashing Process, with revised date of 06/01/25, indicates that Manager must review the log within seven days. Employees responsible for taking and recording concentrations must be trained on these procedures.Date: 3. Document the date the temperature are taken, 4. Meal Period: Circle the meal period where temperatures and sanitizer concentration are taken, 5. Wash Temperature: Document the temperature of the wash cycle.8. Initial: Employee responsible for taking temperature initials. Review of the facility's Food Product Shelf-Life Guidelines policy, with revised date of 01/28/22, it notes in the Safety of food after expiration dates section, Products with a Sell by, best buy or before, or Use-By: Adhere to that date for quality reasons. In the facility's Food Safety Product Labeling and Dating Guidelines policy, with a revised date of 12/06/22, it notes in the Date Marking Non-Time Control for food safety section, Once a product does have a documented use by date, the FDA Food Code and Sodexo Policy requires the product to be consumed or discarded by that date. Review of the facility's Food Storage and Use guidelines, Eggs should be used within 10 days.carrots to be used within one to two weeks.

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	08/01/2025

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

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to assure one of one Resident ((R) 69) sampled for Hospice had a current certification of terminal illness and current Interdisciplinary Group (IDG) Comprehensive Assessment in her hospice binder or electronic health record (EHR). R69's EHR and hospice folder were not updated with current care information putting the resident at risk for not being provided continuity of care at the end of life. Findings Include:On 07/30/25 record review of R69's Electronic Health Record (EHR) and facility provided matrix revealed resident is receiving hospice services. Review of R69's hospice binder revealed it did not have a current hospice certification of terminal illness and the last IDG Comprehensive Assessment Details form from July 2025. On 07/30/25 at 03:45 PM inquired of Director of Nursing (DON) for current hospice certification of terminal illness and IDG Comprehensive Assessment Details form. DON reviewed R69's hospice binder and confirmed it was not in the hospice binder. DON stated she had them on her desk. At this time DON looked for these documents and reported to surveyor they were not on her desk that she would contact the hospice provider. On 07/31/25 at 07:40 AM the DON provided a copy of R69's hospice certification of terminal illness that was dated from 06/18/25 - 08/16/25 and the IDG Comprehensive Assessment Details form dated from 07/28/25 which were faxed to the facility on [DATE] at 16:06 PM. On 07/31/25 at 12:59 PM interviewed DON. Inquired if the facility should have had the current hospice certification of terminal illness and IDG Comprehensive Assessment Details form and the DON confirmed the facility did not have them yesterday and should have had them for this resident.

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	08/01/2025

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to implement the facility's infection prevention and control measures. After exiting a Transmission Based Precaution (TPB) room (a COVID positive resident), Certified Nurse Aide (CNA) 57 was not wearing applicable Personal Protective Equipment (PPE), Registered Nurse (RN) 127 did not perform glove change and any hand hygiene while performing wound care for resident (Resident (R) R104). The facility also failed to assure Resident (R) 67's urinary catheter bag was hanging and not on the ground while he was in bed. These deficient practices placed the resident at risk for developing preventable infections and other adverse health complications. Findings Include: 1) Record review of R67's Electronic Health Record (EHR) on 07/29/25 revealed he is a [AGE] year-old who was admitted to the facility on [DATE]. Review of R67's Minimum Data Set (MDS) Quarterly Assessment with an Assessment Reference Date (ARD) of 07/22/25 revealed his Brief Interview for Mental Status (BIMS) summary score was 13 identifying him as cognitively intact. R67 was also coded as having an Indwelling catheter (suprapubic catheter) under Section H: Bladder and Bowel. Review of the facility provided matrix also coded resident as having a suprapubic catheter. On 07/30/25 at 10:19 AM observed R67's urinary bag on the ground near his bed. At this time requested Registered Nurse (RN) 21 come to R67's room. Inquired of RN21 if R67's urinary bag should be left on the ground and RN21 stated it is supposed to be hanging, that it might have got knocked off the bed frame when or if the resident moved his bedside table. Inquired with R67 if he moved his bedside table and he said no. 2) On 07/29/25 at 09:15 AM, observed CNA57 exiting the room of a Covid positive resident, wearing a regular mask and not a N95 mask. Interviewed CNA57 and she confirmed, she should have been using a N95 mask instead of a regular mask to prevent spread of Covid. On 07/29/25 at 09:30 AM interview with Registered Nurse (RN) 66, noted that for TBP and prevention of the spread of COVID, all staff should be wearing, gloves, gown, face shield, and N95 masks. On 08/01/25 at 08:45 AM interview with Director of Nursing (DON) confirmed that for the prevention of COVID, staff should be wearing N95 masks. On 08/01/25 at 01:15 PM, review of the “Precautions” postage in front of the TBP room noted, “before entering room, everyone must: including visitors, doctors, staff…must use a NIOSH-approved N95 or equivalent.” On 08/01/25 at 01:30 PM, review of the facility's “Infection Control-Transmission Based Precautions” policy, with revised date of 04/17/25, in the “Explanation and Compliance Guidelines” section, it notes for “Airborne Precautions, d. If unable to transfer resident to an AIIR room, as in the case of COVID-19 infection, the facility will follow Center for Disease Center (CDC) guidance…staff will wear N95 or equivalent respirator and other PPE while delivering care to the resident.” (continued on next page)

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	08/01/2025

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/01/25 at 01:30 PM, review of the facility's “COVID-19 Risk Mitigation Plan,” with revised date of 04/17/25, in the “Isolation Strategies and Resident Placement Considerations” section, it notes, “n. Wear appropriate PPE: gown, N95 mask, eye protection and gloves.” 3) On 08/01/2025 at 10:15 AM, observed RN127 performing wound care to R104's sacral ulcer. RN127 cleaned R104's feces with wipes, did not change gloves, and complete any hand hygiene before proceeding with applying wet gauze and foam dressing to R104's sacrum. On 08/01/25 10:30 AM, interview with RN127 noted that they are not supposed to change gloves in between dressing changes (RN127 was to complete sacral and right foot ulcer dressing), but acknowledged she should have changed her gloves and performed hand hygiene after wiping R104's feces prior to applying wet gauze and foam dressing to sacrum. RN127 agreed that changing gloves and completing hand hygiene prevents worsening of R127's sacral infection. On 08/01/25 at 10:46 AM, interview with Unit Manager (UM) 2 confirmed that hand hygiene should be completed before and after each task and going from dirty to clean tasks to prevent infection. On 08/01/25 at 01:00 PM, record review of R104's Electronic Health Record (EHR) noted R104 has stage IV pressure ulcer (PU) to sacrum and right lateral foot. R104's care plan noted he is currently on Intravenous (IV) antibiotic therapy for sacral wound infection. On 08/01/2025 at 11:50 AM, interview with Infection Preventionist (IP) nurse noted that staff are supposed to be changing gloves and doing hand hygiene in between dressing changes. IP also stated that RN127 should have changed PPEs after cleaning feces to ensure that there was no contamination. On 08/07/25 at 12:00 PM, review of the facility's “Wound Care” policies, dated 04/17/25, in the “Explanation and Compliance Guidelines” section, it notes “7. Dressing changes will be completed utilizing proper technique…” Review of the facility's “Hand Hygiene” policy dated 04/17/25, it notes, “Appropriate hand hygiene must be performed under the following conditions: 4. After having prolonged contact with a resident, 5. After handling used dressings…contaminated tissues, 6. After contact with…broken skin, 7. After handing items or work surfaces potentially contaminated with a resident's…excretion and secretions…”