STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125042	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oahu Care Facility	1808 South Beretania Street Honolulu, HI 96826

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 - Some	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** 51870 Based on record reviews and interviews, the facility failed to meet regulatory requirements for Baseline Care Plans (BCP) for three of three Residents (R)1, R2, and R4. Specifically, R1 did not have a BCP developed within 48 hours of admission, R4's BCP did not include the Stage 2 Pressure Ulcer that was present on admission, and two residents were not provided summaries of the BCP. 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 home staff. Findings include: 1) On 03/24/2025 at 10:30 AM, record review of R2s BCP was noted to be blank and not completed. R2 was admitted on [DATE], and comprehensive care plan (CCP) was initiated on 02/28/2025. Further review of R2's electronic medical record (EMR), did not note they were furnished with a copy of their BCP. On 03/24/2025 at 03:00 PM, interview with Director of Nursing (DON) confirmed that the BCP should be completed within 48 hours of resident's admission. Surveyor asked DON to show R2's BCP and noted that it was blank, and stated, I don't know what happened, I will check on it. On 03/25/2025 at 12:00 PM, DON provided a copy of a completed BCP for R2. It was completed by Nursing Supervisor (NS). There was no completion date noted on BCP. On 03/25/2025 at 12:20 PM, interview with NS, who confirmed that she was asked to complete the BCP that morning. When asked when the BCP should be completed, NS replied, It should be completed within 24 hours. On 03/25/2025 at 12:30 PM, interview with DON and Administrator confirmed that if the staff cannot complete the BCP, that the NS will be the one to complete it. At that time, they let surveyors know that the BCP for R2 and another resident were completed late. The Clinical Specialist (CS) said no matter how late the BCP is, it still needed to be completed to move forward in their next step of documentation. The BCP for R2 was completed 03/25/25. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 03/24/2025 at 10:35 AM, record review of R1's EMR did not note they was furished a copy of their BCP. Concurrent record review and interview with DON on 03/24/2025 at 03:00 PM, DON confirmed that summary of BCP was not provided to the resident/guardian. 39853 3) R4 was a [AGE] year old female admitted to the facility for skilled nursing services on 03/19/2025 for short term rehabilitation after being hospitalized for two unwitnessed falls at home. Her medical diagnosis included but not limited to repeated falls, anorexia, severe malnutrition, hypertension, unsteadiness on feet, dysphagia (swallowing disorder), and pressure ulcer of sacral region Stage 2. Reviewed R4's medical records, which included the following: Hospital Discharge Summary dated 03/19/2025 revealed the following entries: - Related to unwitnessed fall; patient lives with special needs son and does not have anyone to take care of her. She is primary caretaker of son. Niece checks on her twice a week and found her down prior to admission.Has frequent falls and states that she uses walker/cane in her home to ambulate due to instability. The hospital discharge instructions included care for Pressure Injury (PU). - [NAME]-Baseline Care Plan was completed on 03/19/2029, and included skin risk. This section documented R4 to have current skin integrity issues, but did not identify the Stage 2 sacral PU present on admission. The signature of Resident and Representative was left blank and no evidence a copy of the BCP was provided to R4 or Representative. 3) Reviewed the facility's care plan policy titled, Care Plans - Baseline with revised date March 2022. The policy documented in the section titled Policy Statement noted, A BCP to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. Also noted in the same policy under section titled Policy Interpretation and Implementation, noted, 3. A comprehensive care plan (CCP) may be used in place of the BCP provided the CCP is developed within 48 hours of the resident's admission. 4. The resident and/or representative are provided a written summary of the BCP (in a language that the resident/representative can understand) .5. Provision of the summary to the resident/or resident representative is documented in the medical record. These policy statements were not followed by the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 39853 Based on record review and interviews, the facility failed to develop a comprehensive care plan (CCP) for one Resident (R)1 of a sample size of three. Specifically, R1's CCP did not address his safety needs in a timely manner. As a result of this deficiency, R1 may have been at higher risk of falls. The deficient practice of not addressing resident's needs timely in the CCP could affect any resident and be a barrier to meeting their highest potential of physical and mental well-being. Findings include: Record review of R1's electronic medical record (EMR) noted that prior to admission on 05/06/2024, R1 was admitted to a hospital with a subdural hematoma (brain bleed caused by trauma) due to falling at home. R1's baseline care plan (BCP) completed on admission to the facility, noted R1 to be cognitively impaired, marked Yes, for fall(s) in the past three months, level of consciousness marked as disoriented x3 at all times, and functional ability and goals were not assessed. Admission progress notes detailed resident was lethargic, disoriented, and oriented to person with mild impairment. Late entry on Admission note specified R1 was a fall risk. Review of the Nurses Notes dated 05/13/2024, at 11:13 AM, documented, R1 was found sitting on the floor with his back leaning against his bed at 02:20 AM. Alert but very confused and hallucinating. He thought that he was at the Club . When asked him if he was only dreaming, he said no and he believed that he was there at the Club. Review of the Nurses Notes dated 05/20/2024 at 00:02 AM, documented, At 2345h (11:45 PM) CNA (certified nurse assistant) found resident sitting on the floor next to his bed. No noted pain, other than his unchanged pain to his coccyx. He was then assisted back to bed.DON (Director of Nursing) and Kaiser notified. On the same day there was a late entry at 03:30 AM: Found resident facing down on the floor, alert c/o pain from head to toe .assisted back in bed with 4 person assist. Abrasion to right elbow 2 cm X 1cm .MD and family notified. MD stated to send to ER for further evaluation d/t (due to) frequent falls and confusion. Record review of R1's care plan noted that The resident is High Risk for falls r/t confusion, deconditioning, gait/balance problems, incontinence, use of Oxycodone (pain medication). Actual fall on 05/13/24-minor injury (complaints of pain), was initiated on 05/16/2024, three days from the initial fall on 05/13/2024. On 03/24/2025 at 03:00 PM, interview with DON, who confirmed that High Risk for falls was not included in R1's CCP on admission, and should have been due to his history. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/25/2025 at 01:00 PM reviewed the facility's care plan policy titled, Falls and Fall Risk, Managing with a revised date of March 2018. In the section titled, Policy Statement noted, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Also noted in the same policy under section titled Resident-Centered Approaches to Managing Falls and Fall Risk, noted, 1. The staff, with input of the attending physician, will implement a resident-centered fall prevention to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on record reviews and interviews, the facility failed to provide repositioning, the standard of care for pressure ulcers (PU/ injury to the skin and tissue below the skin due to pressure on the skin for a long time), and as directed in care plans for three Residents (R)1, R2 and R4 out of a sample size of three. This deficient practice puts residents with PU's at risk of worsening the wound, and increases the potential of those at risk to develop one. Findings include: 1) Cross Reference F655 Baseline Care Plan R4 was a [AGE] year old female admitted to the facility for skilled nursing services on 03/19/2025 for short term rehabilitation after being hospitalized for two unwitnessed falls at home. She had a sacral Stage 2 PU present on admission that was not identified on her baseline care plan. Record review revealed no documentation the R4 had been turned or repositioned until after the treatment administration record (TAR) was initatiated on 03/25/2025. 2) Record review of R1's Minimum Data Set (MDS), noted R1 was admitted on [DATE] with an unstageable wound ulcer to his coccyx and required substantial/maximal assistance with rolling left to right in bed, sitting to lying position, and with transfers. Review of Wound Care Nurse (WCN) notes, dated 05/13/2024, indicated, wound on coccyx is necrotic and malodorous with large, purulent drainage. R1's care plan for unstageable ulcer, initiated on 05/16/2024, included tasks to assist R1 to turn/reposition at least every 2 hours. There was no documentation in R1's TAR that repositioning/turning every 2 hours was completed. 3) Record review of R2s MDS noted that R2 was admitted to the facility on [DATE] with multiple PUs. R2 had a Stage 3 PU on the right buttocks, unstageable wound left buttocks, Stage 2 coccyx, and left ankle ulcers. Review of WCN notes dated 03/21/2025, indicated wounds located on bilateral buttocks and left posterior thigh are smaller in size while the right posterior thigh is healed. R2's care plan initiated on 02/28/2025, included tasks that R2 needs assistance to turn/reposition at least every 2 hours, more often as needed or requested. There was no documentation in R2's TAR that repositioning/turning every 2 hours was completed. 4) On 03/25/2025 at 10:25 AM, interview with Certified Nurse Assistant (CNA)1 inquired how often they would check on the residents with PUs. CNA1 stated, We check up on them every time they have bowel movement, at least three times a day, in the morning after breakfast, again at lunch, and after dinner. When asked about peri care and repositioning, CNA1 replied, We clean them and would report any findings to the charge nurse. We change their position every two hours and document that in the I-pad, under Activities of Daily Living (ADLs), repositioning and sign our name. At 10:30 AM, CNA1 showed surveyor, where in the I-pad, they would document repositioning was completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/03/2025 at 10:40 AM, interviewed CNA2, who confirmed that they check residents with PUs every two hours for bowel and bladder elimination and reposition them every two hours. CNA2 verified that they document these tasks in the ADLs section in the I-pad. Surveyor asked CNA2, to open up R2's chart to see if documentation was noted for repositioning. Documentation showed repositioning on 03/25/2025. CNA2 was asked to show if documentation for repositioning was completed on 03/24/2025, and she confirmed that there was none as she wasn't assigned to R2 yesterday. CNA2 checked another date, 03/11/2025 to see if documentation on repositioning was done by another CNA, but record showed none were documented. It was confirmed that the documentation for positioning started on 03/24/2025. CNA2 went on to note that the CNAs should be documenting every day. On 03/25/2025 at 01:30 PM, interview with Director of Nursing (DON) confirmed the importance of every two hours repositioning for residents with PUs and agreed there should be documentation of the task being done. DON also confirmed that there were no tasks triggered for the repositioning for both R1 and R2 upon admission but will do so to improve the process moving forward. 5) On 03/25/2025 at 01:45 PM, record review of the facility's Repositioning policy, with a revised date of May 2013, documented under General guidelines, states, 1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief.3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning.5. Positioning the resident on an existing pressure ulcer should be avoided since it puts additional pressure on tissue that is already compromised and may impede healing. Also noted in the same policy under the Documentation section, notes, The following should be recorded in the resident's medical record: 1. The position in which the resident was placed. This may be on a flow sheet. 2. The name of the individual who gave the care.7. The signature and title of the person recording the data. These policy statements were not followed by the facility.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interviews, medical record review and document review, the facility failed to provide adequate supervision of one Resident (R)3 of three residents sampled that were high risk of elopement. R3 eloped on 02/09/2025 and suffered harm. When she was found, she was taken to the hospital where she was treated for abrasions from a fall and discharged back to the facility. The facility met the following three criteria for past non-compliance 1) Not in compliance with the regulatory requirement at the time the situation occurred; 2) The noncompliance occurred after the exit date of the last recertification and 3) There is evidence that the facility corrected the noncompliance and is in substantial compliant at the time of this survey. Findings include: 1) The Office of Healthcare Assurance received an initial facility reported incident (ACTS # 11488) on 02/10/2025 regarding an elopement. The report included the following information: -R3 initially admitted to facility on 01/10/2025 for skilled nursing facility services after a hospital admission following an unwitnessed fall with acute traumatic injury of CSpine (C3-C4), Unsteady gait, Multilevel degenerative changes of C-spine, Stage 5 Chronic Kidney Disease and dementia. R3 is pleasant, alert, oriented to self, forgetful of place/situation, able to verbalize needs and understands others, and able to walk with a front wheel walker with supervision. R3 had nondirectable exit seeking behavior on 1/12/2025 and a wanderguard bracelet was determined to be the least restrictive device. -On 2/9/2025 at 4pm [sic] R3 was unable to be found on the facility property and staff initiated the missing resident procedure. The resident was found by a good Samaritan on [NAME] Avenue (several blocks away in high traffic area) and had taken R3 to .ER for evaluation. R3 sustained a minor skin injury on bilateral knees, right elbow, and palm. She returned to the facility accompanied by facility Administrator on 2/9/2025 at 9:22Pm . -R3's wanderguard bracelet was noted in good working condition by day shift RN. On evening shift, RN noted R3's wanderguard triggered by elevator, staff escorted her away, and RN administered medications at 3:26pm. CNA (Certified Nurse Assistant) then escorted her to the dining room to participate in activities. Activity staff were aware resident was in the dining room, but did not observe R3 walking out of the dining room. At 4:00pm, RN started looking for resident to give her next scheduled medication. He looked in the dining room and her room, and resident was not found. Staff began missing resident procedure at approximately 4:10pm. Staff contacted the administrator soon after and called 911. -Upon R3's return to the facility, the facility Administrator and Nursing Supervisor tested the wanderguard bracelet on R3's right ankle and found that the wanderguard bracelet is faulty. The wander guard bracelet did not trigger the elevator door until the Administrator was right in front of the elevator door and called for the elevator. A new wanderguard bracelet was immediately tested and .placed on resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The completed report was received on 02/14/2025 and included the following: -Upon incident on 02/09/2025, RF Technologies (RFT) Senior Service Technician was dispatched (urgent request was submitted immediately) and arrived on 2/12/2025. Technician assessed resident's transmitter bracelet (the one on at the time of elopement) and verified that the equipment was faulty. The hardware (elevator and exit door system) for the WanderGuard transmitter bracelet was tested multiple times, and all devices were found to be working in good condition-please see attached report. 15 minute checks were done immediately upon incident on 2/9/2025, on resident and all other residents wearing the WanderGuard transmitter bracelets until the technician confirmed the system was in good condition. -Additional education was done on 2/10/2025 regarding Wandering and Elopements and Missing Resident policies and procedures. -In conclusion, resident's transmitter bracelet was effective and noted to be working by licensed staff an hour prior to the incident. The transmission bracelet resident had on was later identified to be faulty and malfunctioned .and tested by RFT technician; and thus the technical glitch was determined to have caused the incident. Facility did not identify any problem with the WanderGuard system, and noted to be working properly, also verified and confirmed by technician. -R3 .was discharged as planned on 2/13/2025 .after successful rehabilitation and was transferred to a lower-level of care. 2) Reviewed R3's Hospital Emergency Department Provider record dated 02/09/2025, time seen 06:14 PM. The record included: Chief Complaint: Fall. Location of injuries-right elbow, right wrist and right knee and left knee. The injury occurred just prior to arrival. Occurred on a street. (Apparently a patient at .rehab and eloped undetected. Found on [NAME] Ave with wounds to extremities. Unwitnessed fall. Patient does not recall what happened.She complains of pain in right elbow and wrist). Skin: (Multiple large skin tears involving right elbow and bilateral knees). Neuro: Altered mental status: disoriented to place and time. Course of Care:Wounds were thoroughly irrigated and dressed . R3 was discharged back to the facility with the nursing home manager. 3) Reviewed the facility policy titled WanderGuard Device, which included but not limited to the following: 1. Residents will be assessed for the need of WanderGuard bracelet at the time of admission and as needed. 3. The Director of Nursing or designee will be notified of any residents assessed for the need of the WanderGuard bracelet. (continued on next page)

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