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	05/20/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure an effective discharge planning process was developed and implemented which considered the care giver's availability, capacity, and capability to perform needed care, to meet the needs of the resident following discharge for one out of three residents sampled. This deficient practice resulted in an unsafe discharge. Findings include: On 05/19/26 at 09:10 AM, conducted a review of Resident (R) 2's Electronic Health Records (EHR). R2 was admitted on [DATE] to the facility with diagnosis which include, but not limited to, congestive heart failure, dysphagia, end-stage renal disease, and cognitive communication deficit. The resident was discharged on 03/04/26. The discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/04/26, documented in Section C. Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Review of the resident Care Conference Summary conducted on 02/16/26 at 05:48 AM (Locked on 02/27/26 at 11:06 PM) which documented, .Plan is to return home with brother who is cognitively and physically impaired as well, daughter expressing concern, SS (Social Services) present and aware . and Care conference held with IDT (Interdisciplinary Team), resident, and niece. Niece's concerns were more related to resident being discharged with brother who cannot care for him (R2) while facing his (brother) own health challenges . On 05/19/26 at 10:09 AM, conducted a telephone interview with R2's Family Member (FM) 1 regarding R2's discharge. FM1's understanding of the discharge was that R2's insurance could only cover 20 days of the stay, R2 was not ready to go home. He had a G-tube, dialysis, he was being unsafe, attempting to removing the G-tube, and FM4 has the mentality of a toddler and cannot manage R2 at home. The discharge plan was for R2 to go home with FM4. FM1 reported it was not the family's preference to have R2 live with the FM4. FM1 reported working with an agency to have the resident approved for another payment form and the facility was aware of this. FM1 confirmed feeling pressured by the facility to follow through with the unsafe discharge to FM4's home, despite informing the Social Worker (SW) multiple times that FM4 could not safely care for R2. FM1 stated, I verbally told SW it is not safe for R2. I did not agree or confirm the discharge plan the facility implemented. Inquired if FM4 was a part of the discharge planning process, FM1 confirmed FM4 did not participate in the discharge planning process due to lack of mental capacity to participate in the process. FM1 reported having text messages with SW, which confirmed that the facility was aware of FM4's inability to safely care for R2 upon discharge. On 05/19/27 at 11:45 PM, reviewed text messages between FM1 and SW. According to the text messages, leading up to the discharge, FM1 applied R2 for Medicaid long term coverage (LTM) as an alternative to discharging R2. FM1 why Adult Protective services have not been called because FM1 emphasized many times he/she cannot support R2. SW continued attempting to coordinate pick-up times and appointment times despite FM1 reporting there is no support for R2. FM1 informed SW that she cannot assist coordination of the discharge at this time, questions why R2 is being discharged to a situation where the level of care R2 requires cannot be met, there is no support at the discharge residence, he may choke or cause harm to himself, needs more time at the facility so that SW can complete the job and ensure R2 has the (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right level of care R2 requires when discharged . SW responded that R2 is only at the facility short-term with a discharge plan as home with brother. The facility is aware that R2 couldn't afford copay and wasn't agreeable to copay that is why we planned to discharge R2 today and this was the discussion during the care conference. On 05/20/26 at 09:47 AM, conducted a concurrent interview and record review (through a cellular phone) with SW. Inquired how the facility assessed the physical environment and the caregiver's ability to provide needed services for R2. SW replied that they ask about the physical environment. Inquired who did the facility speak with, SW reported that the facility attempted to call FM4 and confirmed the facility did not have any form of communication with FM4. When asked if FM1 informed the facility that it was not a safe place for R2 to be discharge due to FM4's inability to care for R2. SW responded that she would get back to the surveyor on that and did not provide an answer. During this interview, SW confirmed the cellular phone number used to communicate with FM1 as the same phone number FM1 exchanged text messages with. A second interview was conducted with SW on 05/20/26 at 01:15 PM. During this interview SW was informed that the text messages with FM1 were provided to this surveyor. SW then stated SW stated that FM1 may have verbalized something to the effect that FM4 could not safely care for R2 upon discharge. Asked SW if FM1 was informing the facility that it was not a safe discharge and the facility had no conversations with FM4, and FM1 was working on LTM, in hindsight was it a safe discharge and what could have been done instead of discharging R2. SW confirmed it was not a safe discharge and looking back R2 should have stayed in the facility, R2's LTM was approved.On 05/20/26 at 01:27 AM, conducted an interview with the Director of Nursing (DON). Inquired if the facility had a conversation with FM4 regarding R2's discharge to his residence. DON stated the facility did not speak to FM4, only to FM1. DON also confirmed knowledge that FM1 did not live in the same residence as FM4. Inquired how the facility evaluates the capacity, capability, and availability of the caregiver the resident is being discharged to. DON replied, it is not necessarily the practice of the facility to evaluate the ability and capability of the caregiver. Family would be the one to ensure safety. Inquired with DON, if the family is reporting that the planned discharge caregiver is not capable and does not have the capacity to provide needed care, and the facility has not had contact with the discharge caregiver, is it a safe discharge. DON replied, the resident wanted to go home.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a discharge summary included a recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and and/or consultation results for one of three residents sampled. As a result of this deficient practice, relevant information was not relayed to the appropriate care provider. Findings include: Definition: Recapitulation of Stay- A concise summary of the resident's stay and course of treatment in the facility. On [DATE] at 09:10 AM, conducted a review of Resident (R) 2's Electronic Health Records (EHR). R2 was admitted on [DATE] to the facility with diagnosis which includes, but not limited to, congestive heart failure, dysphagia, end-stage renal disease, and cognitive communication deficit. The resident was discharged on [DATE]. Review of progress notes documented R2:Was dependent on dialysis services and would not always complete the entire dialysis treatment as prescribed.Would present as confused and reported looking for deceased mother (multiple occasions), attempted to enter into a co-female resident's room and needed reorientation.Difficulty sleeping and administered medication.Became agitated, combative hitting and swearing at staff, saying mom.Complaints of lower back pain 9/10.Went to the emergency department (ED) for not responding to tactile or verbal stimuli, with eyes closed. Had medication adjustments for Hypotension. Physician notified for hypertension and prescribed medicationReceived medication for agitation and restlessnessPeriodic medication refusalNon-complaint, he gets up and walks in hallway with his walker without helpWanderguard alarm placed of right ankle due to episode of elopement, exit seeking behaviorsChronic disorganized thinking, confusion, requires cues, oriented to personPEG-tube (feeding tube) removed, no reason or assessment found Review of the facility's Discharge Summary included only:Resident NameDischarge Statusadmit date discharge date Medical record NumberPrognosis: GoodSummary: Did well in rehab. GT (PEG tube) was removed. On [DATE] at 10:05 AM conducted a concurrent interview and record review of R2's EHR with the Medical Director (MD) via telephone. Requested for the MD to review the Discharge Summary and inquired if it provides a recapitulation of R2's stay at the facility. MD confirmed the discharge summary was not sufficient and would have liked to see more information, especially information on the removal of R2's PEG tube. During an interview with the Director of Nursing (DON) on [DATE] at 01:27 PM, requested for the DON to read the prognosis and summary of the Discharge Summary due to not being legible. DON read prognosis: good and Summary: Did well in rehab. GT was removed. Inquired if this was a recapitulation of R2's stay at the facility. DON responded that it captured the removal of the PEG tube and agreed with the discharge summary.