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	08/29/2024

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on record review and interview, the facility failed to inform a resident of the risks and benefits of the use of psychotropic drugs and obtain consent for one of five residents (Resident (R)3) sampled for unnecessary medications. As a result of this deficiency, the resident was placed at risk for more than minimal harm. Findings include: R3 was an [AGE] year-old resident admitted to the facility on [DATE]. Diagnoses included but not limited to anxiety disorder, dementia, and major depressive disorder. Ordered medications included mirtazapine and duloxetine (antidepressants). Review of R3's Electronic Health Records (EHR) documented the consents for the use of the psychotropic medications including education on the risks and benefits were not found. On 08/28/24 at 12:34 PM, requested from Director of Nursing (DON) a copy of the consents for the use of antidepressants for R3. DON said he will look in the paper files since R3 was already on the medications before the facility switched over to the EHR. On 08/29/24 at 07:58 AM, the DON confirmed he was not able to locate the consents for the use of the antidepressants for R3.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Oahu Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 1808 South Beretania Street Honolulu, HI 96826	

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 42160 Based on observations, interviews, and record review, the facility failed to ensure a resident's right to be free from physical restraint for staff convenience and not required to treat the resident's medical symptoms for one resident (Resident (R)5) sampled. Positioning wedges were placed under R5's mattress and under the resident's fitted sheet in a manner which could not be removed by the resident, which hindered the resident from freely moving at will. An interview with staff confirmed the positioning wedges were not used to reposition R5 and the resident is capable of independently moving around in bed. As a result of this deficient practice, residents with the ability to move independently are at risk of the potential for more than harm. Findings include: On 08/26/24 at 11:50 AM, 12:30 PM, and 02:05 PM, observed a large black positioning wedge and pillow placed under the bed's mattress. The placement of the positioning wedge and pillow caused the mattress to be concaved and restricted the resident from freely moving around. Inquired with the resident if he was able to move side to side independently while lying on the mattress, the resident tried and was unable to do so and reported he needed help. The resident confirmed he can move side to side by himself. On 08/27/24 at 07:55 AM, 09:03 AM, 11:47 AM, and 01:40 PM observed a positioning wedge placed under the resident's fitted sheet on both sides of the bed, parallel to the resident's legs only. The wedges were not placed under the resident and did not function to reposition the resident. Resident confirmed the wedges did stop him from moving to his side and could not remove the wedge from under the fitted sheet. On 08/27/24 at 01:40 PM, conducted concurrent observation and interview with Registered Nurse (RN)4 of R5 in bed with the wedges placed under the sheet. RN4 confirmed the placement of the wedges under the resident's fitted bed sheet, made it impossible for this resident to remove the wedge, was not placed in a manner consistent with repositioning the resident, and was not being used to treat a medical condition. RN4 stated, The way the wedges are placed under the sheet, on both sides of the resident, the wedges are being used as a restraint. Wedges should have only been placed on one side if we want to reposition him, but he (R5) can move side to side on his own and doesn't need to be repositioned by staff to prevent a pressure ulcer. He (R5) is a high fall risk and has fallen out of bed recently, we try our best but cannot be with him all the time. Asked RN4 if a bed alarm was implemented for the resident. RN4 confirmed R5 does not have a bed alarm and it should have been implemented after the resident's last fall but was not. Review of R5's skin integrity care plan, did not include using a wedge to reposition the resident. A care plan for R5's high fall risk and an elopement was developed and did not include the use of wedges. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure (provided by the facility), Use of Restraints documented 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition and this restricts his/her typical ability to change position or place, that device is considered a restraint.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on record reviews and interviews, the facility failed to provide written notification of the bed hold policy to the resident or the resident's representative for two of the five residents (Resident (R)6, and 167) sampled for hospitalization . As a result of this deficient practice, there was a potential for miscommunication. This has the potential to affect all the residents that are transferred to an acute care hospital. Findings include: 1) R6 is a [AGE] year-old resident admitted to the facility on [DATE]. Review of R6's electronic health record (EHR) revealed that she was transferred to an acute care hospital on 03/13/24 for acute lower GI (gastrointestinal) bleeding. R6's EHR did not contain documentation that R6's representative was provided a written notification of the facility's bed hold policy. On 08/29/24, requested a copy of the written notification of the bed hold policy provided to R6's representative from the Director of Nursing (DON). DON said he will check. On 08/29/24 at 04:14 PM, the Social Worker Designee (SWD) provided a printout of the progress notes from R6's EHR that stated the bed hold policy was communicated via phone call with the family representative. Asked SWD if a written copy of the bed hold policy was also provided. SWD confirmed the facility did not provide the resident representative a written copy of the bed hod policy. Review of the facility policy titled Notice of Bed-Hold and Readmission Policy stated, . In order to bed-hold, the resident or the resident's responsible party or agent must complete, sign and submit the BED-HOLD AGREEMENT within twenty-four (24) hours of discharge and pay a deposit . 37954 2) Record review on 08/28/24 of R167's EHR found she was transferred to an acute hospital on 07/23/24 at 5:25 PM for pain r/t (related to) fractures of her Right Hip and Right shoulder that she incurred from a fall (unwitnessed) in her room at 1305 (1:05 PM) this afternoon. On 08/29/24 at 03:46 PM, interviewed SWD and inquired if R167 or her resident representative was notified of the facility's bed hold policy at time of transfer to the hospital. SWD confirmed resident or resident representative was not notified of bed hold policy.

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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. 42160 Based on interviews and record review, the facility failed to ensure a comprehensive person-centered care plan was implemented for one resident (Resident (R)56) sampled. R56's person-centered care plan included an intervention to use alternative communication tools (i.e. interpreter services, available for staff use) for this Korean speaking resident. Staff did not implement the use of interpreter services intervention when conducting the Brief Interview for Mental Status (a tool used to assess the resident's cognition). As a result of this deficient practice, all non-English speaking residents are at risk of the potential for more than minimal harm. Findings include: On 08/27/24 at 12:28 PM, conducted an observation of R56 in the unit's main dining room during lunch. The resident was seated next to another Korean speaking resident and conversed with each other throughout lunch. When R56 was done with her meal, facility staff approached R56 and attempted to have a conversation with the resident in English. R56 waived her hand at the staff then said No, English, then said something to the other resident in Korean and both residents proceeded to laugh and continue their conversation. Staff kept attempting to speak and interact with R56 about the meal but was unable to effectively communicate with the resident. Reviewed R56's Electronic Health Record (EHR). The resident's baseline care plan Section 1.B. Communication documented: 1. Can the resident communicate easily with staff? No 2. Does the resident understand the staff? No 3. Does the resident need or want an interpreter to communicate with a doctor or health care staff? Yes 4. Primary Language: Korean Review of R56's admission Minimum Data Set (MDS) with an Assessment Reference Date of 06/14/24 documented in Section C. Cognitive Patterns, R56 scored 99 on Brief Interview for Mental Status (BIMS) score, which assesses the resident's cognition, indicating the test could not be completed. R56's comprehensive person-centered care plan for communication documented an intervention which included . Use alternative communication tools as needed. On 08/29/24 at 12:13 PM, conducted an interview with the MDS Coordinator (MDSC). MDSC confirmed she conducts the BIMS testing with the residents. MDSC stated the facility's interpreter service has never been used to communicate with non-English speaking residents to conduct a BIMS test. MDSC confirmed R56 scored a 99 on the admissions BIMS score due to the resident's inability to understand English and is not an accurate BIMS score for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/29/24 at 01:57 PM, conducted a concurrent record review of R56's Electronic Health Record (EHR) and interview with Registered Nurse (RN)5. RN5 confirmed R56 is Korean speak and is minimally (i.e. tired, sleepy, hungry) able to communicate with staff, but is not able to understand complex statements. RN5 reported R56 is cognitively aware, she is observant of staff, and was able to incrementally find a way to elope from the facility. RN5 explained R56 eloped from the facility, she was cognitive enough to figure out that the Wander guard would prevent her from being able to get off the elevator, but she was determined to leave. R56 noticed staff inputting a code to disarm the Wander guard system and even attempted to input a code. Eventually, she was able to find a scissor in a manicure set, cut off the Wander guard bracelet which activates the system and prevented the resident from leaving the facility, and was able to exit the building and cross the street. RN5 stated most of the behaviors and the elopement attempt could have been mitigated if interpreter services were implemented to discover what was the real issues and to explain the circumstances of why the resident was in the facility in the first place. RN5 confirmed R56 is minimally interactive with staff who are only English speaking, but she will sit a have conversations with another Korean speaking resident.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on record review and interview, the facility failed to develop a discharge plan for two of 18 residents (Resident (R)61 and R219) sampled. The discharge needs and/or discharge goals for these residents were not identified to ensure the residents are ready for discharge according to their individual needs. As a result of this deficient practice, residents are at risk for more than minimal harm related to an unsafe discharge from the facility and/or a readmission to the facility. Findings include: Review of the facility policy titled, Care Plans, Comprehensive Person-Centered stated, . The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes . c. includes the resident's stated goals upon admission and desired outcomes . 1) R61 is a [AGE] year-old resident admitted to the facility for short-term rehabilitation on 07/24/24. During an interview with R61 on 08/26/24 at 11:48 AM, R61 said he was only at the facility short-term. R61 reported he is from another island and was here to have his knees taken care of. Review of R61's Electronic Health Record (EHR) documented the resident's comprehensive care plan identified the resident is in the facility for short -term rehabilitation but did not include a discharge plan, measurable objectives, or timeframes the resident would need to meet prior to being discharged from the facility. Without a discharge plan including necessary goals to ensure the resident's individual needs were met to be safely discharged from the facility, the resident is at risk of being readmitted and/or injury due to a premature discharge. 2) R219 is a [AGE] year-old resident admitted to the facility on [DATE] for short-term rehabilitation after hospitalization for a chronic right leg wound. During an interview in the dining area on 08/27/24 at 10:16 AM, R219 said he wanted to go back home when he is strong enough to walk a short distance. Conducted a review of R219's EHR comprehensive care plan which documented the resident was admitted for short term rehab (rehabilitation) but did not include a discharge plan, measurable objectives, or timeframes for the resident prior to discharge. An interview and concurrent record review was conducted with the Director of Nursing (DON) in the conference room on 08/29/24 at 07:56 AM. Asked DON to find the discharge plan for R61 and R219 in the EHR to review. DON accessed the residents HER and reviewed their comprehensive care plans, then confirmed both residents did not have a comprehensive discharge plan. DON stated expectation for residents admitted to the facility for short-term rehabilitation services is to have a discharge care plan documented in the EHR.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 37954 Based on interviews and record review the facility failed to ensure Resident (R)122 is provided appropriate services for communication. As a result of this deficient practice, non-English speaking residents are at potential risk for more than minimal harm. Findings include: On 08/27/24 at 09:10 AM before going into R122's room inquired with Registered Nurse (RN)17 if they use interpreter services with resident and she stated she does not think they are. Administrator overheard and stated they are using interpreter services because she receives the bill and pays it each month. On 08/27/24 at 09:13 AM, attempted to interview R122 and she said, No English. On 08/28/24 at 01:48 PM, conducted an interview with Admissions Staff (AS)2 and she confirmed an admission packet was provided to R122 and she completed R122's admission. Inquired about English as a second language for R122. AS2 stated she would speak slowly for resident and R122 was comfortable with this. AS2 also stated the facility has Korean speaking staff at the facility, the resident ask to use an interpreter, and the Administrator speaks Korean. Inquired if staff were used as an interpreter during this time and AS2 confirmed staff was not used to complete the admission process. Record review of R122's Electronic Health Record (EHR). A pre-admission form documented R122's primary language is Korean, and the resident's English-speaking ability is very limited. R122's current care plan for Impaired communication skills d/t language barrier. Prefers to speak in Korean. Sometimes makes self-understood and understand others was initiated 08/26/2024 and revised on 08/26/2024, while surveyors were onsite. Provide translator as necessary to communicate with the resident. Date Initiated: 08/26/2024 Revision on: 08/26/2024. COMMUNICATION: Resident requires interpreter with communication. Date initiated: 08/28/2024. Revision on 08/28/2024. Review of R122's progress notes confirmed interpreter services was not offered or used with resident since her admission, for any care provided, when family and friends were not available.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on observation, interviews and record review, the facility failed to ensure the environment remains as free of accident hazards and adequate supervision to prevent accidents for one resident (Resident (R)56) sampled. A nurse's scissor was left unattended in an area accessible to resident and not properly stored. R56 was not adequately supervised, had access to a scissor, and managed to elope from the facility without staff's knowledge. As a result of this deficient practice, residents are at risk of more than minimal harm. Findings include: 1) Observation on 08/26/24 at 11:55 AM, before walking out of a non-COVID room on the second floor observed an N95 mask on the rack that is used to store chux and adult briefs. Inquired with Certified Nurse Assistant (CNA)5 if the N95 mask belongs in the room and he stated he did not know who put it there and said he would throw it away. CNA5 picked up the N95 mask to throw away and behind the N95 mask was a pair of metal scissors on the shelf. On 08/26/24 at 12:15 PM, inquired with Nursing Supervisor (NS) if scissors are left in residents' room and she confirmed the scissors are not left in resident's room and she picked up the scissors. Inquired where the scissors are kept, NS stated the treatment cart. On 08/29/24 at 02:41 PM, requested a facility policy regarding sharps/scissors from Administrator. On 09/03/24 at 02:21 PM, Administrator emailed facility policy titled Safety and Supervision of Residents. Review of this policy found Policy Statement Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 42160 2)R56 is an [AGE] year-old woman who was admitted to the facility on [DATE] with diagnosis which include hypotonic hyponatremia (an increase of free water in relation to sodium in the fluid outside of the cell), encephalopathy (damage to the brain), depression, suicidal ideations, hypertension (high blood pressure 140/90 millimeter of Mercury (mmHG)), and Dementia. Review of R56's Electronic Health Record (EHR) progress notes documented R56 used scissors from a manicure kit stored in the resident's bedside stand to cut off the wander guard and allowed the resident to exit the building without triggering the facility's elopement security system: On 07/10/24 at 06:45 PM, Patient left facility unattended. Wonder guard off patient, found in bedside drawer. Wonder guard had been on patient prior to her removing and leaving the facility. CNA 72 observed patient crossing the street and assisted patient back into facility. CNA also notified and went out to patient to speak to patient in Korean and assist back into her room. Patient confused and upset stating she doesn't want to wear Wonder guard and wants to leave . Patient agreed to wear and not take off. Wonder guard on right wrist. Patient remains in stable condition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/11/24 at 12:45 PM, Scissors were found in resident's bedside stand in a manicure kit. Scissors were then labeled and stored in locked med cart. Review of R56's admission Minimum Data Set (MDS) with an Assessment Reference Date of 06/14/24 documented in Section C. Cognitive Patterns, R56 scored 99 on Brief Interview for Mental Status (BIMS) score, which assesses the resident's cognition, indicating the test could not be completed. On 08/29/24 at 12:13 PM, conducted an interview with the MDS Coordinator (MDSC). MDSC confirmed she conducts the BIMS testing with the residents. MDSC stated the facility's interpreter service is not used to communicate with non-English speaking residents to obtain an accurate BIMS score. MDSC confirmed R56 scored a 99 on the admissions BIMS score due to the resident's inability to understand English and the resident speaks Korean. On 08/29/24 at 01:57 AM, conducted a concurrent record review and interview with Registered Nurse (RN)5 regarding R56's elopement. RN5 confirmed R56 is cognitive and is very aware of her surroundings. RN5 explained, prior to R56 eloping, the resident tested out the Wander guard system. R56 set off the alarm several times when trying to get on the elevator. She saw staff putting in a code to disarm the Wander guard system and staff observed R56 attempting to put in the code to disarm the system, but she was unable to disarm the alarm without staff knowing. Eventually, R56 figured out it was the bracelet that activated the Wander guard system, and the resident got a scissor from her personal kit and cut the Wander guard band off her wrist and managed to get out of the building and across the street. RN5 confirmed staff underestimated how [NAME] the resident is and showed how high functioning the resident's cognitive functioning really is. Asked RN5 if R56's care plan was updated after the resident eloped to ensure the resident's safety.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47783 Based on interview and record review, the facility also failed to ensure the records for controlled medications were maintained and accurate. As a result of this deficient practice, there is a potential for the diversion of a controlled medication. Findings include: On 08/28/24 at 08:24 AM, an inspection of the medication cart on the second floor was conducted with Registered Nurse (RN)9. While checking the controlled medications logs with RN9, reviewed a log for the administration of morphine sulfate (opioid pain-relieving medication). Observed that a dose was administered on 08/16/24 at 11:01 PM but there was no signature of the staff who gave it to the resident. RN9 confirmed that the staff who administered the medication should have signed the log immediately after giving it. Review of the facility policy titled Controlled Substances stated, . 4. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record . c. Signature of the nurse administering the dose .

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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. 37954 Based on observations, interviews, and record review, the facility failed to properly store physician prescribed topical ointment for one resident (Resident (R)22) and failed to ensure medicated ophthalmic drops were properly labeled with an expiration date for two residents (Resident (R)32 and 52) sampled. As a result of this deficient practice, residents who receive prescribed cream, ointment and medicated ophthalmic drops are at risk for more than minimal harm. Findings include: 1) On 08/28/24 record review of R22's Care Plan (CP) found she has a CP in place for: The resident has bowel/bladder incontinence d/t impaired mobility. At risk for skin breakdown/UTI, or falls. Has potential for constipation. Date Initiated: 06/26/2021 Revision on: 09/04/2021. The resident will remain free from skin breakdown due to incontinence and brief use through the review date. Date Initiated: 06/26/2021 Revision on: 07/09/2024 Target Date: 10/15/2024. Administer Triad paste to groin and perianal area MASD. Date Initiated: 04/26/2024 LPN RN Clean peri-area with each incontinence episode. Date Initiated: 06/27/2021 CNA LPN RN Medications as ordered. Date Initiated: 07/27/2023 RN LPN On 08/29/24 at 10:05 AM observed peri-care for R22. R22 was in her bed and stated, I'm wet. Certified Nurse Assistant (CNA)12 was at the bedside with R22. Inquired of CNA12 if she applies the triad paste to the resident after she provides peri-care and CNA12 opened R22's bedside table, pulled open the drawer, and took out three medicine cups. Two of the three medicine cups had R22's name and room number. Each medicine cup had either a paste/cream or an ointment. Inquired again of CNA12 if she applies the triad paste after peri-care and CNA12 stated let me get the nurse. On 08/29/24 at 10:30 AM interviewed Registered Nurse (RN) 4. Surveyor told RN4 of medication cups with creams and ointments that were found in R22's bedside table. Inquired of RN4 if medicine cups with ointments and creams that are ordered by the physician are to be left at the resident's bedside and she confirmed they are not to be left at the bedside. RN4 stated she had put prescribed ointment for R22 in a medicine cup for another nurse who worked the day before (08/28/24) with her because the other nurse did not have access to the ointment which is kept locked in the treatment cart. RN4 apologized and stated she assumed the nurse had put the ointment on R22. Review of the facility's policy, 4.1 Storage of Medication documented Policy Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. (continued on next page)

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	08/29/2024

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	42160 2) On 08/28/24 at 07:45 AM, conducted an inspection of the 3rd floor medication cart with RN5. Observed three (3) bottles of ophthalmic drops: Resident (R)32's Brimonidine Tartrate-Timolol Ophthalmic Solution 0. 2-0.5 % (Brimonidine Tartrate-Timolol Maleate) and Lumigan Ophthalmic Solution 0.01 % (Bimatoprost); R52's Latanoprost Ophthalmic Emulsion 0.005 % (Latanoprost) were not labeled with the date the solutions were opened or an expiration/discard by date and there was no way to confirm when the medicated ophthalmic drops were opened. RN5 confirmed the three (3) bottles of ophthalmic solutions were not labeled with the date the bottles were open or when the bottles should be discarded by, and the bottles should have been labeled. Review of the facility's policy and procedure, Medications and Medication Labels documented, Multi-dose vials shall be labeled to assure product integrity .Nursing staff should document the date opened on multi-dose vials on the attached auxiliary label.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024

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

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on observation and interview the facility failed to ensure staff use non-expired test strips for their kitchen three compartment sink to test for levels of strength of sanitizer solutions, failed to store clean meal lids on a rack that did not have rusty colored debris and failed to label opened beverages with the opened-on date. Findings Include: 1) Observation on [DATE] at 10:40 AM had kitchen staff test the strength of sanitizer in their three compartments sink and found facility was using expired Hydrion test strips with an expiration date of [DATE]. Food Service Worker (FSW) 11 confirmed the test strips were expired and got new test strips and tested the water which was in range. 2) On [DATE] at 10:57 AM while observing tray line observed a rack in the kitchen near the stove, which held clean lids for resident meals, had rust colored debris. Inquired with Dietary Manager who confirmed there was rust colored debris and stated, need to change it out. 3) On [DATE] at 09:50 AM observed nourishment refrigerator on the second floor. While looking at food and juices in the refrigerator found orange juice, prune juice and cranberry juice were open but not dated with the opened-on date. Inquired with Nursing Supervisor who confirmed juices are to have the opened-on dates on them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER: Oahu Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 1808 South Beretania Street Honolulu, HI 96826	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on observations, interviews, and record reviews, the facility failed to implement infection prevention and control measures when providing care for residents on isolation. The facility did not ensure that staff were wearing applicable personal protective equipment (PPE) when providing care to residents on transmission-based precautions (TBP). This deficient practice placed the residents at risk for the potential spread of infections and communicable diseases. Findings include: On 08/26/24 at 11:03 AM, observed postings on the door of room [ROOM NUMBER] that stated, Special Droplet/Contact Precautions. The posting also stated that eye protection, gown and gloves are required when entering the room. Registered Nurse (RN)9 confirmed that one of the residents in room [ROOM NUMBER] recently tested positive for COVID-19. On 08/26/24 at 11:39 AM, observed Physical Therapist Assistant (PTA)1 in room [ROOM NUMBER] talking to Resident (R)61. PTA1 was not wearing a gown and did not have a face shield or eye protection. PTA1 then exited the room to speak to another staff member, put on a gown and reentered room [ROOM NUMBER]. PTA1 did not have a face shield or eye protection when he went back in. On 08/28/24 at 08:47 AM, an interview was conducted with the Director of Nursing (DON) in the hallway just outside room [ROOM NUMBER]. DON confirmed that all staff are expected to wear a gown, gloves, mask and face shield or eye protection when entering rooms assigned to residents on TBP. Review of facility policy titled Coronavirus Disease (COVID-19) - Using Personal Protective Equipment stated, . b. Eye Protection: (1) Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) is applied upon entry to the resident room or care area. d. Gowns: (1) A clean isolation gown is donned upon entry into the resident room or area. 37954 2) On 08/26/24 at 09:11 AM observed on the second floor a plastic container that held PPE such as gloves in various sizes, disposable gowns, N95 and surgical masks. This was kept outside of a resident's room who tested positive for COVID. PPEs were placed outside the room near the door for staff to put on before entering the room and the red biohazard trash can with lid was next to the PPE container. Across the hall there was another PPE container next to a regular trash can that did not have a lid, placed outside another resident's room who also tested positive for COVID. On 08/26/24 at 11:28 AM second observation done on the second floor found a red biohazard trash can left outside of a resident's room who tested positive for COVID. At this time inquired with the Nursing Supervisor why it was not in the room, and she stated there was no room and that it would create a fall risk for the residents in the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER: Oahu Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 1808 South Beretania Street Honolulu, HI 96826	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/27/24 at 08:20 AM Administrator shared with surveyor why facility had PPEs, biohazard and regular trash cans outside resident rooms who tested positive for COVID. Administrator stated facility had a meeting with an Infection Control Consultant and shared what the consultant wrote in an email to Administrator on 09/22/23 at 4:04 PM I understand you are in the window for survey. If they ask why they are bringing doffed PPE in the hallway bin, explain the lack of space in the room does not allow a large trash bin and if you put one it could pose a safety risk for the residents and cause falls or injury to them .Explain you are looking at over the door PPE caddy's and over the door trash bag holder for the used PPE. At no time during survey was over the door PPE caddy's and over the door trash bag holder for the used PPE observed in the resident's rooms who tested positive for COVID. Review of facility policy titled Coronavirus Disease (COVID-19) - Using Personal Protective Equipment stated under Policy Interpretation and Implementation . 2. When caring for a resident with suspected or confirmed SARS-CoV-2 infection, personnel who enter the room of the resident will adhere to standard precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. c. Gloves (1) Non-sterile gloves are applied upon entry into the resident care room or care area. (3) Gloves are removed and discarded before leaving the resident room or care area, and hand hygiene performed immediately. d. Gowns (1) A clean isolation gown is donned upon entry into the resident room or area. (3) The gown is removed and discarded in a dedicated container for waste or linen before leaving the resident room or care area.