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	11/18/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect and promote quality of life for 1 of 1 resident (Resident (R)68) sampled for dignity by ensuring that he was treated with the respect and consideration any reasonable person would expect. Specifically, the facility failed to ensure staff provided feeding assistance in a manner that considered proper pacing and dignity. As a result of this deficient practice, R68's dignity was compromised, and he was placed at risk of a decreased quality of life. Findings include: Resident (R)68 is a [AGE] year-old male admitted to the facility on [DATE]. R68's current diagnoses include, but are not limited to, dysphagia (difficulty swallowing), and functional quadriplegia (the complete immobility of all four limbs due to a severe disability or frailty from a medical condition. It means the person cannot move their limbs, requiring total assistance with daily activities). A review of his most recent Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/11/2025 confirmed that R68 was found to be fully dependent on facility staff for all activities of daily living (ADLs) including eating, hygiene, toileting, showering/bathing, dressing, transfers, and mobility. On 09/24/2025 at 8:10 AM, observed Restorative Nurse Aide (RNA)3 as she was feeding R68 his breakfast of pureed food. RNA3 fed R68 with a metal spoon at a moderate to quick pace, spoonful after spoonful, getting pureed food all over his mouth, chin, and nose despite the fact that R68 was not moving his head excessively. Observed RNA3 use the metal spoon to wipe up the excess of pureed food she had given, including what was on and under his nose, put it in his mouth, then continue to use the same spoon to feed him the remaining food. RNA3 stood over R68 while feeding him. Once done with feeding him, and after RNA3 had left the room with his meal tray, an interview was attempted with R68, however he would neither make eye contact nor respond to questions. On 09/25/2025 at 1:44 PM, an interview was done with the Director of Nursing (DON) regarding dignity while assisting a resident to eat. When asked about R68, DON acknowledged that he does not move a whole lot when eating. DON also agreed that care should be taken when feeding him, and staff should try to ensure pureed food does not get on his nose. When observations were shared with DON, she agreed that any reasonable person would not feel it was dignified to use a spoon to wipe excess food off their face, chin, and nose, then continue using it to spoon more food into their mouth. DON explained that she would expect staff to use a napkin to wipe/clean the excess. Review of the facility's policy and procedure, Assistance with Meals, last revised 03/2022, revealed the following: Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to accurately record the type of discharge in the RAI, Minimum Data Set (MDS) for one Resident (R)92 of three residents sampled. As a result of this deficiency, the facility put R92 at risk for further RAI, MDS inaccuracy.Findings include:Review of Electronic Health Record (EHR) showed R92 was admitted on [DATE] with diagnoses including Metabolic Encephalopathy, Intestinal Obstruction, Anemia, Chronic Obstructive Pulmonary Disease, Bipolar Disorder, Hypertension, Depression.Review of the most recent MDS, Assessment Reference Date 09/06/25, Section A310G, type of Discharge was inaccurately marked as Unplanned Discharge which meant that the discharge was not expected and did not follow the discharge plan. Review of Electronic Health Record (EHR), progress notes showed that R92 was discharged home on [DATE], as expected and followed the discharge plan.During staff interview on 09/26/25 at 12:20 PM, MDS Coordinator acknowledged that R92 was inaccurately marked for Unplanned Discharge. MDS Coordinator said that they would immediately make the necessary correction.Review of the Long-Term Care Facility RAI 3.0 User's Manual read the following: The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20(b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status. In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

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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 - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that 2 of 3 residents (Residents (R)8 and R84) sampled for pressure ulcers received the necessary monitoring, treatment, and services, consistent with professional standards of practice and their comprehensive care plans, to promote healing and prevent worsening. Specifically, the facility did not monitor/document the wound status of the pressure ulcers. As a result of this deficient practice, there was no way to measure if the treatment being provided was effective or needed to be modified. Findings include: 1) Resident (R)8 is an [AGE] year-old female admitted to the facility on [DATE] for hospice/end-of-life care. A review of her Minimum Data Set (MDS) admission Comprehensive Assessment, with an Assessment Reference Date (ARD) of 08/28/2024 revealed that she was admitted with a Stage 4 pressure ulcer (bed sore classification meaning there was full-thickness tissue loss extending into muscle, bone, or tendons) on her coccyx (tailbone). Review of R8's provider orders noted an order since 12/20/2024 for daily and as needed dressing changes to the wound on her coccyx. The order was changed to increase the dressing changes to every day and every evening shift (twice daily) on 06/11/2025. Further review of provider orders noted an order to conduct a Weekly Skin Assessment every Wednesday night. Review of R8's Comprehensive Care Plan revealed the following interventions for the goal of The resident's Pressure ulcer will show signs of healing and remain free from infection: Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD [doctor]. Revision on: 08/22/2024 Monitor/document/report PRN [as needed] any changes in skin status: appearance, color, wound healing, s/sx [signs/symptoms] of infection, wound size (length X width X depth), stage. Date Initiated: 08/22/2024On 09/25/2025 a review of R8's electronic health record (EHR) revealed no documentation of wound status found either on the Treatment Administration Record (documenting twice daily dressing changes), in the nurse progress notes, or on the Weekly Skin Assessment(s). Closer review of the Weekly Skin Assessments requested from the facility for the last four weeks revealed no Weekly Skin Assessment done for the week of 09/08/2024, and of the Weekly Skin Assessments that were done, the following was consistently documented: Skin Issue: #001: Skin issue has not been evaluated. Location: Coccyx. Issue type: Pressure ulcer/ injury. Pressure ulcer staging: Stage 4 Pressure ulcer/ injury. On 09/25/2025 at 1:38 PM, an interview was done with the Director of Nursing (DON). Regarding documentation expectations, DON disclosed that if facility staff are doing a dressing change, she expects there to be a nurse progress note that includes a wound assessment. In addition, DON agreed that the Weekly Skin Assessment should include a wound assessment documenting wound status and appearance. On 09/26/2025 at 7:40 AM, an interview was done with Registered Nurse (RN)2, who reported that she had been the facility Wound Nurse for 6-7 years. When asked who was responsible to document wound status. RN2 answered that if a resident was not on wound rounds [weekly wound assessment/treatment done by wound care consultants], as R8 was not, the wound assessment should be documented by the nurse who does the Weekly Skin Assessment. During a concurrent review of R8's Weekly Skin Assessments for the last month, RN2 confirmed that they should be documenting wound status assessments for every identified skin issue but did not. RN2 agreed that it is important to know what the wound status is and what the wound looks like to ensure that R8 is comfortable and that her pain is managed appropriately. 2) R84 is an [AGE] year-old female admitted to the facility on [DATE]. R84 was discharged home on [DATE] and re-admitted to the facility on [DATE]. Review of her MDS admission Comprehensive Assessment, with an ARD of 09/10/2025 revealed that she was re-admitted with a Stage 4 pressure ulcer to her right hip and an unstageable (bedsore classification for a wound covered by dead tissue or scab-like tissue that prevents the depth of the wound from being determined) pressure ulcer to her right ankle. Review of R84's provider (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders noted orders for daily dressing changes to her wounds. Further review of provider orders noted an order to conduct a Weekly Skin Assessment every Monday on day shift. Review of R84's Comprehensive Care Plan revealed the following interventions: Provide wound care per treatment order . Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage. On 09/25/2025 a review of R84's EHR revealed no documentation of wound status found either on the Treatment Administration Record (documenting daily dressing changes), in the nurse progress notes, or on the Weekly Skin Assessment(s). Closer review of the Weekly Skin Assessments revealed the following was consistently documented: Skin Issue: #001: Skin issue has not been evaluated. Location: Rear right trochanter (Hip) . Pressure ulcer staging: Stage 4 Pressure ulcer . #002: Skin issue has not been evaluated. Location: Rear right malleolus [ankle] . Pressure ulcer staging: Unstageable pressure ulcer .On 09/26/2025 at 7:54 AM, an interview was done with RN2 regarding R84's wound care. As the Wound Nurse, RN2 reported that because R84 was not on wound rounds, the expectation is that wound assessments should be documented on the Weekly Skin Assessments and are done by the assigned unit/floor nurse. During a concurrent review of R84's Weekly Skin Assessments since readmission, RN2 confirmed that they should be documenting wound status assessments for every identified skin issue but did not. RN2 agreed it could not be determined what the status of R84's wounds were because there had been no documentation that they had been assessed in 3 weeks.

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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 observation, interview, and record review, the facility failed to ensure 1 of 2 residents (Resident (R)68) sampled for limited range of motion (ROM) received the appropriate treatment, equipment, and services, to increase mobility or prevent further decrease in ROM. As a result of this deficient practice, R68 was placed at risk of decreased mobility and comfort and hindered from reaching his highest practicable well-being. Findings include: Resident (R)68 is a [AGE] year-old male admitted to the facility on [DATE]. R68's current diagnoses include, but are not limited to, contracture (tightening and shortening of muscles, tendons, skin, and other soft tissues, causing joints to become stiff and limiting their normal movement), and functional quadriplegia (the complete immobility of all four limbs due to a severe disability or frailty from a medical condition. It means the person cannot move their limbs, requiring total assistance with daily activities). A review of his most recent Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/11/2025 confirmed that R68 was found to be fully dependent on facility staff for all activities of daily living (ADLs) including eating, hygiene, toileting, showering/bathing, dressing, transfers, and mobility. The same assessment also documented that R68 had not received Restorative Nursing Programs services, including, but not limited to, active or passive range of motion, splint or brace assistance, and/or training and skill practice in bed mobility or transfer in the last 7 calendar days . On 09/23/2025 at 1:40 PM, observed R68 sitting in his wheelchair in the dining room. R68 had his left wrist drawn up to his chest with a contracture (flexing/bending) visible of less than 20 degrees (space between the palm pad and the inner aspect of his wrist).On 09/24/2025 at 8:12 AM, an interview was done with Restorative Nurse Aide (RNA)3, who said she had been working with R68 since his admission. When asked about a wrist splint, RNA3 reported that R68 had one before, but it had not been applied for a long time. RNA3 explained that there were no current orders for a wrist splint. Concurrent observation of R68 noted his left wrist was drawn up to his chest with a contracture of less than 20 degrees.A review of R68's provider orders noted the following 07/16/2025 order: D/C [discontinue] OT [occupational therapy] after treatment on 7/15/25. Will pick back up after splints arrive. Further review confirmed there were no active splint orders. Review of R68's Comprehensive Care Plan revealed the following interventions under the Focus of Resident is on RNA program, last revised on 07/07/2025: Perform RNA program as scheduled. Document refusal and reason for refusal. RNA Program: Range of Motion (Passive) Date Initiated: 07/07/2025 Revision on: 07/07/2025 RNA Program: Range of Motion (Active) Date Initiated: 07/07/2025 Revision on: 07/07/2025 RNA Program: Splint or Brace Date Initiated: 07/07/2025 Revision on: 07/07/2025Review of Occupational Therapist (OT)1's 07/15/2025 Treatment Encounter Note revealed documentation of increased LUE [left upper extremity] flexor [bending that decreases the angle between bones on two sides of a joint] tone . tolerated PROM [passive range of motion] with BUEs [both upper extremities]. No significant change in ROM, d/t [due to] splints being delayed . specialized splint to arrive in 2-3 weeks . D/C'd [discontinued] patient from therapy until splints arrive.On 09/26/2025 at 8:10 AM, an interview was done with the Director of Rehabilitation (DOR) and OT1. OT1 confirmed that she had ordered a special splint to address R68's left wrist contracture around 07/07/2025, then discontinued OT services on 07/15/2025 pending arrival of the splint, however RNA services should have continued. DOR confirmed that no follow-up on the splint order had been done since July, but when she called this morning, she discovered that there would be an additional delay. Both DOR and OT1 agreed that follow-up should have been done earlier than this morning. OT1 explained that had she known about the continued difficulty in receiving the splint, she would have assessed whether she needed to modify the treatment plan or not. When asked about what type of RNA Program should be currently implemented, OT1 explained that she filled out a Restorative Hand-Off Form in July and gave it to the (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RNAs. OT1 reported that the Rehabilitation (Rehab) office did not keep copies of those forms but that it should be on the unit in the RNA binder. On 09/26/2025 at 8:30 AM, an interview was done with Unit Clerk (UC)1 who reported that there were no RNAs scheduled on the unit for the day, and she did not know where the RNA binder was. Current RNA Hand-off Form was requested from the facility, however by survey exit, the most recent RNA Hand-off Form located was dated 06/01/2023, and applied to R68's lower extremities only.

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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. Based on observation, interview, and record review, the facility failed to provide one resident sampled for smoking (Resident (R) 12) with an ashtray made of non-combustible material while he was smoking, and the facility's designated smoking area did not contain a metal container with a self-closing cover device to dispose of cigarette butts and ashes. This deficient practice did not ensure the safety for R12 and other residents in the facility that smoke.Findings include:On 09/23/25 at 12:23 PM, observed R12 being assisted by Activity Aide (AA) 10 via wheelchair to the designated smoking area located outside of the facility near the Administration building. On the way, AA10 stopped with R12 at the ground floor station near the kitchen and asked Administration Assistant (NAA) 5 for an ashtray. NAA5 responded that the ashtrays were missing. AA10 proceeded with R12 to the designated smoking area without an ashtray. The designated smoking area did not contain a metal container with a self-closing cover device to safely dispose of cigarette butt and ashes. When R12 was done with smoking a cigarette, he ran the cigarette butt on the concrete ground and gave it to AA12 who then put it in his pocket. Prior to R12 leaving the designated smoking area, NAA5 arrived with a small metal container without a self-closing cover and asked AA10 for the cigarette butt to place in that container.On 09/26/25 at 7:20 AM, interviewed NAA5 regarding the ashtrays used for smoking. NAA5 voiced that staff who escort residents who smoke, will come and get the ashtray from her station on the ground floor before proceeding to the designated smoking area. NAA5 then showed a round, black colored container with holders on the rim and a black colored cylindrical container. Both did not contain a self-closing cover device.On 09/26/25 at 07:23 AM, AA10 confirmed that after he received the used cigarette butt by R12 he placed it in his pants pocket since there was no ashtray available. A policy titled, Smoking Policy - Residents with a revised date of October 2023 stated, 5. Metal containers, with self-closing cover devices, are available in smoking areas.

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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. Based on observation, interview, and record review the facility had no defined policy and procedure on how to manage the disposition for discontinued non-controlled medications located in the medication administration cart. This deficient practice creates a potential unsafe situation where discontinued medications could inadvertently be administered to residents in the facility.Findings include:On 09/25/25 at 08:22 AM, medication cart A on the second floor of the facility was checked. While checking the medications in the drawers, Registered Nurse (RN) 8 identified medication for three residents were discontinued but remained stored in the medication cart (NovoLog (Aspart) insulin pen for Resident (R) 19 and R29 and Nicotine Patches for R12). A concurrent review of the Electronic Health Record (EHR) showed 09/24/25 discharge orders for R19 and R29's Novolog insulin pen. RN8 stated she was the one that received the discontinuation order. The Nicotine patch had a discontinuation date of 08/29/25 noted in the EHR. RN8 stated the three medications should have been removed from the cart, however, was unable to describe the specific procedure for removal and destruction.A review of three facility medication policies titled, Medication Administration, Medication Labeling and Storage, and Discarding and Destroying Medications received on 09/25/25 at 11:35 AM was done. All three policies were dated 2001 MED-PASS at the bottom of each the pages. None of the three polices contained specific procedures on the disposition process for discontinued non-controlled medications.On 09/26/25 at 10:40 AM, Interviewed the DON in her office. DON explained that when a non-controlled medication is ordered to be discontinued, it is removed from the cart, with no defined time frame to do so, and placed in the Nursing Supervisor's office which is a secured room. A nurse will then eventually destroy the stored medications. DON stated that for safety reasons, she would like discontinued medications to be removed from the medication cart by the end of the shift. The night shift nurse could do a double check regarding the order for the discontinuation of the medication and removal from the medication cart. If okay, it would be destroyed at that point. DON was made aware that none of the three medication policies (Medication Administration, Medication Labeling and Storage, and Discarding and Destroying Medications contained specific facility procedures and time frames for the removal and destruction of non-controlled medications that are discontinued.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor the medication regimen for 1 of 6 residents (Resident (R)45) sampled for unnecessary medications. Specifically, the facility failed to monitor for and appropriately document episodes of excessive sleepiness despite identifying it as a problem. As a result of this deficient practice, R45 was placed at risk of avoidable accidents related to adverse effects of potentially unnecessary medication(s). Findings include:Resident (R)45 is an [AGE] year-old female admitted to the facility on [DATE]. R45's current diagnoses include, but are not limited to, dementia and insomnia. A review of her provider orders noted the following:11/26/2021: monitor hours of sleep every shift.07/01/2022: melatonin (a sleep aid supplement) 3 milligrams (mg) at every bedtime for sleep aid. Scheduled for 7:00 PM. 06/20/2023: l-tryptophan (a sleep aid supplement) give 2 capsules at bedtime for sleep aid. Scheduled for 9:00 PM.04/02/2025: mirtazapine (a medication with sleepiness and tiredness listed as very common side effects) 7.5 mg at every bedtime for anorexia. Scheduled for 9:00 PM. Review of R45's Progress Notes revealed a Nutrition/Dietary Note documented on 09/09/2025 at 8:47 AM with the following: Chewing/Swallowing: OOB [out of bed] and on a seating position during mealtime with meals for Aspiration [when foreign material, such as food, liquid, or stomach contents, accidentally enters the airway and potentially the lungs] precautions 1:1 [one to one] supervision to assistance as needed too sleepy.On 09/23/2025 at 9:08 AM, an initial observation was made of R45 sleeping in bed with her breakfast tray sitting on the bedside table untouched. At 9:57 AM, second observation made of R45 still sound asleep in bed. Nurse Aide (NA)4 at the bedside trying to wake her (unsuccessfully); breakfast still sitting on the bedside table untouched. NA4 explained that she had heard that R45 was awake all night and did not sleep until 5:00 AM. Licensed Practical Nurse (LPN)1 entered the room and shared that besides not waking for breakfast, she had not given R45 her morning medications yet because she was too sleepy, and LPN1 was worried about her aspirating. LPN1 explained that R45 will cycle through staying up for days then sleeping for a couple days straight. Confirmed with both NA4 and LPN1 that this was not the first time R45 had been noted to be extra sleepy during normal waking hours. Review of LPN1's Health Status Note written on 09/23/2025 at 10:17 AM about the incident revealed the following documented: Resident refused morning medication. Resident awake all night.Notably absent from the progress note was any mention of excessive sleepiness. Review of R45's Treatment Administration Record (TAR) for 09/22/2025 revealed she was documented as sleeping a full 8 hours on the overnight shift (the previous shift).Review of R45's Medication Administration Record (MAR) for the month of September revealed the mirtazapine, melatonin, and l-tryptophan had been administered every night without fail. Review of R45's Comprehensive Care Plan (CP), MAR, TAR, and provider orders, noted no monitoring specifically for excessive sleepiness. The monitor hours of sleep every shift order had been implemented on the TAR with a numerical entry required each 8-hour shift, with no consideration or way to document the quality of those hours of sleep or when in the shift those hours took place. For example, if documented for 5 hours of sleep on the day shift, were the night shift hours running into those day shift hours to make consecutive hours of sleep, or did R45 take a nap in the middle of the day shift? On 09/25/2025 at 1:29 PM, an interview was done with the Director of Nursing (DON). Upon hearing of the observation of R45's excessive sleepiness, and reviewing the provider orders, DON agreed that if staff are aware of excessive sleepiness, she would expect to see it documented in a progress note. DON confirmed that at a minimum, she would expect monitoring for excessive sleepiness to be a part of the CP. DON also agreed that it was important to document incidents of excessive sleepiness to help the provider determine if any of the sleep aids (or medications such as mirtazapine) could potentially be decreased or discontinued.

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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 observation, interview, and record review, the facility failed to ensure appropriate protective and preventive measures for communicable diseases and infections as evidenced by: 1) Failing to ensure staff followed transmission-based precautions (additional measures used to help stop infection transmission when a patient/resident has been found to be infected or colonized with certain infectious agents), wearing and cleaning proper personal protective equipment (PPE), keeping dedicated equipment in the room, and 2) Failing to label and properly store a nasal cannula. As a result of the deficiencies, the facility put the residents at increased risk to communicable disease and infections. Findings include: 1) On 09/23/2025 at 8:37 AM, while doing an initial tour of the third floor, observed Special Droplet/Contact Precautions signage outside of room [ROOM NUMBER] with instructions for anyone entering to put on the following PPE: mask or respirator, face shield or goggles, gown, and gloves. The signage also indicated: Use patient dedicated or disposable equipment. Clean and disinfect shared equipment. In addition, the signage indicated that the residents in beds B, C, and D were affected. Concurrent interview with Registered Nurse (RN)3 confirmed that the room contained residents who had been found positive for COVID-19 (COVID). Review of the facility's Transmission Based Precaution: Droplet/Contact precaution training material used to in-service staff on 09/18/2025 regarding the topic COVID outbreak in service [sic], Follow right proper PPE and COVID (+) TBP instruction revealed the following: Staff should continue to wear recommended PPE for COVID, N95 mask, Gown, Gloves and face shield. On 09/23/2025 at 12:08 PM, observed Nurse Aide (NA)5 in the doorway of room [ROOM NUMBER] carrying the lunch trays in to the residents. NA5 was not wearing an N95 respirator. Concurrent interview with Licensed Practical Nurse (LPN)1, who also observed NA5 in the doorway, confirmed that she should have donned an N95 before entering the room. At 12:21 PM, NA5 had still not exited the room, nor had she put on an N95. Interview with LPN1 confirmed that NA5 had stayed in the room to assist feeding one of the residents. On 09/23/2025 at 12:24 PM, observed NA5 exit room [ROOM NUMBER], take off her face shield, and hang it on a hook outside the door without cleaning it. Concurrent interview with NA5 confirmed she had not put on an N95 to enter the room. When asked if she should have worn one, NA5 answered, yes but I cannot breathe in that one [N95]. When asked if face shields should be cleaned after exiting the room, NA5 answered, no. When asked a second time if the face shields are cleaned between uses, NA5 again answered no. On 09/23/2025 at 2:25 PM, observed Certified Nurse Aide (CNA)6 enter room [ROOM NUMBER] with no gown, gloves, N95, or face shield, grab the basket of dedicated vital sign equipment from a shelf in the closet and bring it out of the room. Concurrent interview with CNA6 confirmed that she should have put on the appropriate PPE before entering the room. When asked why she removed the equipment from the COVID room, CNA6 answered that she had removed it so that she could clean the equipment. CNA6 agreed that best practice would be to clean the equipment in the room and not bring it out. On 09/24/2025 at 2:17 PM, an interview was done with covering Infection Preventionist (IP)2 and the (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	11/18/2025

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON). IP2 shared that the residents in beds 312B and 312C had been cleared from COVID TBP on 09/22/25 but confirmed that the signage outside the door did not reflect that. Both IP2 and DON agreed that staff are trained and expected to follow the signage that is posted. On 09/25/2025 at 2:05 PM, an interview was done with IP1, who confirmed that for COVID-positive rooms, staff are expected to put on a gown, gloves, face shield, and N95 prior to entering the room, and regardless of which resident they are going in to see. For example, even if a resident in the room has been cleared of COVID, if the room is still on droplet/contact precautions, then the TBP applies to the entire room. When asked about when the face shields are cleaned, IP1 answered that they should be cleaned upon exit of the room but also between residents within the room. When asked about cleaning dedicated equipment, IP1 confirmed that to minimize the risk of carrying infectious agents out of the room, dedicated equipment should be cleaned in the room. 2) On 09/24/25 at 09:33 AM, observed Resident (R) 97's undated and uncovered nasal cannula wrapped around the handle of the oxygen concentrator positioned on the left side of R97's bed. On 09/25/25 at 07:52 AM, observed R97's oxygen concentrator running and the prongs of the nasal cannula on the ground while resident was not in the room. On 09/25/25 at 07:52 AM, observed Resident (R) 1's undated and uncovered nasal cannula wrapped around the right enabler located at the head of the R1's bed. R1 was in bed asleep. On 09/25/25 at 08:34 AM, interviewed Registered Nurse (RN) 9 in R1's room. RN9 responded that proper storage of the nasal cannula when not in use is a brown bag labeled with the resident name and date. On 09/25/25 at 02:44 PM, a facility policy titled, Departmental (Respiratory Therapy) – Prevention of Infection with a revised date of November 2011 stated, Steps in the Procedure. Infection Control Considerations Related to Oxygen Administration.7. Change the oxygen cannulae and tubing every seven (7) days, or as needed. 8. Keep the oxygen cannulae and tubing.in a plastic bag when not in use. Marking the date on the cannula or plastic storage bag was not noted in the policy.