STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl City Post Acute	919 Lehua Avenue Pearl City, HI 96782

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record reviews, the facility failed to follow proper food handling and storage practices in accordance with professional standards for food service safety. Specifically, the facility failed to keep bulk food items off the floor in the storage room and did not label two containers of food brought in by family/visitors in one of three unit refrigerators sampled. Unsafe and/or unsanitary food handling and storage practices have the potential to affect all residents, visitors and staff who have meals served by the facility, placing them at risk for serious complications from foodborne illness as a result of their compromised health status. Findings include: 1) On 04/06/26 at 08:17 AM, an initial tour of the facility's kitchen and interview with the Dietary Manager, were done. Observed seven boxes of instant food thickeners on the floor of the dry storage area. The Dietary Manager confirmed the boxes of food items should not be on the floor. On 04/08/2026 at 9:36 AM, review of the facility's policy and procedure titled Food Receiving and Storage with a revision date of November 2022, stated, . 5. Food in designated dry storage are kept at least six (6) inches off the floor . 2) On 04/06/26 at 12:00 PM, the resident refrigerator, located in the third-floor dining room (P3), was checked. Two containers of cut fruits were observed labeled with Resident (R)47's name but no expiration or use-by date was found. The containers were checked by Registered Nurse (RN)20 who confirmed that it was brought in by visitors of R47 and was not labeled by the facility with an expiration date. On 04/06/26 at 12:05 PM, interviewed Activity Assistant (AA)10 in P3 dining room, who stated that food items brought in from the outside should be dated and is kept for three days. On 04/09/26 at 08:37 AM, interviewed the Dietary Manager (DM) right outside of the kitchen. DM stated that family/visitors are allowed to bring in food for the residents and Nursing or Activity staff should label the food item with the resident's name, room number and expiration date. DM stated that no matter what type of food item is brought in, it should only be kept for three days and then discarded. A facility policy titled, Foods brought by Family/Visitors, dated 2021, stated, . 5. Food brought in by family/visitors that is left with the resident to consume later is labeled and stored . a. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the time and the use by date . 6. The nursing staff will discard perishable foods on or before the use by date.

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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Pearl City Post Acute	919 Lehua Avenue Pearl City, HI 96782

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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** Based on record review and staff interview, the facility failed to ensure that the resident's court-appointed guardian was informed, in advance, of the risks, benefits, and available treatment alternatives related to psychotropic medications prescribed by the physician for one of five residents (Resident (R) 74) reviewed for unnecessary medications. This puts R74 at risk of receiving unnecessary psychotropic medications without informed consent.Findings Include:R74 was admitted to the facility on [DATE] with diagnoses of unspecified mood (affective) disorder, insomnia, and history of falling. On 10/04/24, R74 was deemed incapacitated and a court-appointed guardian with unlimited authority was established. Review of R74's physician orders document R74 was receiving the following psychotropic medications; olanzapine 5 milligrams (mg) once a day for major neurocognitive disorder effective 03/04/26, paroxetine HCl 10mg once a day for major neurocognitive disorder effective 08/22/24 and trazodone HCl 25 mg at bedtime for depression effective 03/03/26. Review of R74's Electronic Health Record (EHR), indicated that consent forms for use of psychotropic medications, paroxetine and olanzapine, including risk and benefits, were signed by a family member dated 08/22/24, not the court-appointed guardian. Documentation further revealed the court-appointed guardian was notified of the psychotropic medication, olanzapine until 04/06/26. Review of R74's Medication Administration Record (MAR) for March 2026 and April 2026 showed R74 received these psychotropic medications daily. Review of the pharmacist's Medication Regime Review (MRR) dated 03/21/26 documented a recommendation for the facility to update the signed consent forms to reflect the current medication regimen, noting recent dose decreases for trazodone and olanzapine. On 04/08/26 at 01:30 PM, an interview with Registered Nurse (RN)12 was conducted. RN12 confirmed there was no documentation that the court-appointed guardian had been informed of the risks and benefits of the prescribed psychotropic medications when the facility became aware of the guardian status. RN12 further confirmed the guardian was not informed in advance of medication changes. RN12 stated there were changes to olanzapine and trazodone, and a note was later observed instructing staff to contact the guardian on 04/06/26, at which time verbal consent was obtained. Review of the facility's policy and procedure Psychotropic Medication Use revised on 02/25, documented . Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with resident/representative prior to obtaining documented or refusal: . non-pharmacological alternatives; . the indications and rationale for the recommendation; the potential risks and benefits . and the resident's/representative's right to accept or decline the treatment.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview, and record review, the facility failed to identify, support, and honor the preferences for one of one resident (Resident (R)47) sampled for Choices. The facility failed to honor R47's preference to be assisted outside the facility for fresh air wearing the hospital gown. As a result of this deficient practice, R47 did not have his needs met and was placed at risk of not attaining his highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include:On 04/06/2026 at 12:15 PM, an interview was done with R47 and family member (FM) at bedside. When asked about the right to make choices in his daily life that were important to him, R47 stated that he wishes he could go outside for some fresh air and sunlight. R47 also explained that he wanted to go down to the ground level with family member but was told that the facility will not allow residents to go outside unless they are wearing regular street clothes. On 04/08/26 at 08:36 AM, an interview was conducted with the Nursing Supervisor (NS)11 in her office. When asked about the right to make choices for R47's preferred clothing when going outside the facility, NS11 confirmed that facility should honor the resident's choice for clothing they prefer to wear. On 04/09/2026 at 09:32 AM, review of facility policy titled Dignity with a revision date of October 2025 stated, . 2. Resident goals, preferences, values.are respected and honored to the extent possible . 5 . residents are supported in exercising their rights . c. dress in clothing they prefer .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interview, the facility failed to provide a clean, comfortable and homelike environment, as evidenced by a heavy buildup of dust on the fans for Resident (R)83 and R109. This deficient practice could affect all residents in the facility if their environment is not kept clean, putting them at risk for increased adverse health conditions. Findings include:1) On 04/06/26 at 09:41 AM, observed R109 lying in bed with head elevated and eyes closed. R109 had a tracheostomy tube (surgically created opening in the neck to establish an airway) and was on supplemental oxygen via tracheostomy collar (plastic mask worn around neck to deliver humidified oxygen). Observed a fan turned on and was directed at R109. The front and back screens of the fan had a buildup of a light grayish substance. 2) On 04/08/26 at 08:34 AM, observed Registered Nurse (RN)12 administer medications to R83. Observed a heavy buildup of a light grayish substance on the front and back screens of the fan that was being used and directed at R83. R83 had a tracheostomy tube and was connected to a ventilator (machine used to provide mechanical breathing to patients unable to breathe on their own). On 04/09/26 at 08:49 AM, concurrent interview and observations were done with Nurse Supervisor (NS)9 at R109's bedside. Queried NS9 how often are the fans used by the residents inspected and cleaned. NS9 said the fans are checked every week and cleaned as needed. NS9 acknowledged that the fan being used for R109 was dusty and said she will have housekeeping clean it. At 09:50 AM, checked the fan being used for R83 with NS9. NS9 acknowledged that the fan had a heavy buildup of dust and turned it off.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that two of four sampled residents (Resident (R)3, and R8) were free from physical restraints. Specifically, the facility failed to document when the restraints were applied and released. As a result of this deficient practice, R3 and R8's rights were violated, and were placed at risk of avoidable injury and/or a decline in their psychosocial well-being. Findings include:1) R3 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. On 04/06/26 at 10:06 AM, and 02:05 PM, observations were done with R3 at bedside. R3 observed wearing mitten restraint on right hand. The placement of the mitten restraint was ordered to prevent R3 from pulling out tube connected to his tracheostomy (surgically created opening in the neck) and gastrostomy tube (medical device inserted through the abdomen and into the stomach used to deliver food, fluids and medications). Review of R3's Treatment Administration Record (TAR) dated 04/07/26 instructing the staff to release mitten restraint to right hand every two hours and as needed revealed that it was marked YES at 09:50 PM. No other form of documentation was found in R3's Electronic Health Record (EHR). On 04/08/26 at 02:6 PM, conducted concurrent interview and record review with Nursing Supervisor (NS)9 in her office. When asked if staff document observations of the resident and when the restraint is applied or removed, NS9 concurred. NS9 said, The staff were releasing the mitten but was only documented on 04/07/26. On 04/08/2026 at 02:44 PM, review of facility policy titled Use of Restraints with a revision date of 04/17 stated, .12. The following safety guidelines shall be implemented and documented . c. A resident placed in a restraint will be observed at least every thirty (30) minutes.resident's condition shall be recorded in the resident's medical record 2) R8 was an [AGE] year-old resident admitted to the facility on [DATE] for long-term placement. Diagnoses included but not limited to mild cognitive impairment, chronic respiratory failure with a tracheostomy and ventilator (machine used to provide mechanical breathing to patients unable to breathe on their own) dependence. On 04/06/2026 at 11:53 AM, observed R8 lying in bed with head elevated. R8 had mitten restraints applied to both hands. On 04/07/2026 08:34 AM, 12:39 AM and 03:07 PM, observed R8 with mitten restraints applied to both hands while lying in bed. Review of EHR revealed mitten restraints were ordered on 10/16/25 to prevent R8 from pulling on tracheostomy tube and ventilator lines. Review of Care Plan with a revision date of 03/16/26 stated, . Document restraint use and release as per facility protocol. Further review of the EHR conducted and documentation of use and release of the restraint was not found. 04/09/2026 at 08:52 AM, concurrent interview and record review was done with NS9 in her office. Queried NS9 where staff document when they use and release the mitten restraint for R8. NS9 said (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the staff document in the EHR under Task. NS9 navigated to the log and only found documentation for 04/07/26 and 04/08/26, no other documentation was found in the EHR. NS9 acknowledged that the staff were not documenting when the restraint was applied and when it was released.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a psychotropic medication was necessary to treat a specific, diagnosed, and documented condition and an as needed (PRN) antipsychotic medication order was limited to 14 days without exception for two of five residents (Resident (R)74 and R13) reviewed for unnecessary medications. This puts residents at risk for unnecessary use of psychotropic medications, including use as chemical restraints, which may lead to over-sedation, confusion, falls, and decreased quality of life, and violates their right to receive medications only when clinically indicated. Findings Include:1) R74 was admitted to the facility on [DATE] with diagnoses of unspecified mood (affective) disorder, insomnia, and history of falling. Review of R74's physician orders revealed the resident was prescribed the antidepressant trazodone 25 milligrams (mg), one tablet at bedtime for depression. Review of R74's Electronic Health Record (EHR) revealed no documented diagnosis of depression. Review of discharge documentation from the acute care hospital and admission records to the facility also did not include a diagnosis of depression. Review of the facility's quarterly geriatric depression assessment dated [DATE] indicated R74 scaled at a 4, reflecting low risk for depression, with no follow-up assessment indicated. On 04/08/26 at 01:22 PM, an interview was conducted with Registered Nurse (RN)10. RN10 confirmed R74 does not have a diagnosis of depression and stated trazodone was prescribed upon admission due to nighttime restlessness. Review of the facility's policy and procedure Psychotropic Medication Use revised on February 2025, stated, . Psychotropic medication management is an interdisciplinary a process that involves the resident, family, and/or the representative and includes . determining adequate indications for use . Residents who have not used psychotropic medications are no prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnoses and documented in the medical record . 2) Review of R13's physician orders revealed an order for the antipsychotic medication quetiapine fumarate 25mg, 0.5 tablet, PRN for agitation, initiated on 03/05/26 with a duration of three months. On 04/08/26 at 01:48 PM, an interview was conducted with Registered Nurse (RN)12. RN12 confirmed that PRN antipsychotic medications should not be prescribed longer than 14 days, and is considered a chemical restraint. Review of the facility's policy and procedure Psychotropic Medication Use revised on February 2025, stated, . PRN orders for psychotropic medications are limited to 14 days . For psychotropic medications that ARE antipsychotics: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews, the facility failed to report an injury of unknown origin that resulted in serious bodily injury for one of one resident (Resident (R)63) reviewed for abuse. The facility did not ensure that the injury was reported immediately, but no later than two hours after identification, to the State Survey Agency (SA) and Adult Protective Services (APS). Specifically, while providing care, a staff member observed that R63's contracted right shoulder and elbow unusually loose. Subsequent X-rays confirmed a fracture of the right humerus (upper arm bone). Despite this finding, the facility did not report the injury within the required timeframe. Findings Include: Review of R63's Electronic Health Record (EHR) revealed that on 08/05/26, a Restorative Nursing Aide (RNA) reported to the primary nurse that the contractures in R63's right shoulder and elbow appeared more loose while assisting the resident with dressing. Nursing documentation indicated an assessment was completed, noting right arm swollen and that the resident cried during turning. An X-ray was ordered the same day. Review of the X-ray results dated 08/05/26 revealed an acute mildly displaced fracture of the mid humerus, with a recommendation for an orthopedic consultation. On 08/06/26, R63 was transferred to the emergency room for further evaluation and treatment. On 04/07/26 at 12:52 PM, a telephone interview was conducted with R63 representative (RR2). RR2 reported that the facility was unable to determine how the resident sustained the fracture to the right arm. On 04/08/26 at 11:55 AM, an interview was conducted with Director of Nursing (DON). DON confirmed that the facility did not report the injury of unknown origin to the SA. The DON acknowledged that, in consideration of reporting requirements and timeframes, the injury should have been reported, even though the physician later assessed the fracture as pathological. Review of the facility's policy and procedure Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating indicated that injuries of unknown source are to be reported to the administrator immediately. The policy further stated that allegations involving abuse or injuries resulting in serious bodily injury must be reported within two hours to the State Survey Agency (SA), ombudsman, resident representative, Adult Protective Services (APS), law enforcement, the attending physician, and the medical director.

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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. Based on observation, interview and record review, the facility failed to recognize and put preventive measures in place to prevent the potential development of pressure injury for one of one resident (Resident (R)2) utilizing a nasal cannula to receive oxygen. This deficient practice put all residents that utilize a nasal cannula at risk for potential development of medical device related pressure injury. Findings include:On 04/07/2026 at 08:51 AM, R2 had an oxygen nasal cannula with the cannula prongs in her nostrils and tubing under her chin, along her cheek bones and looped around her ears. The cannula tubing was observed pressing into her right facial cheek bone area. When the oxygen cannula was lifted from that area an indentation mark and redness was noted to the cheekbone area that the cannula was pressing into. On 04/07/2026 at 10:30 AM, R2's right cheekbone skin area remained with the indentation mark and redness. On 04/08/2026 at 09:10 AM, observed the oxygen cannula tubing pressing against the same right cheekbone area for R2 with an indentation mark and redness to the skin area under the cannula and immediately surrounding the cannula area. On 04/08/2026 at 09:22 AM, a review of R2's care plan listed care plans for Risk of Skin breakdown, Pressure ulcer risk, Respiratory, and Oxygen therapy. All did not include any specific interventions to check a resident's pressure points (e.g. nares, cheeks, chin, ears) while oxygen cannula was in use and to protect tubing contact points. On 04/08/26 at 11:20 AM, interviewed the Wound Nurse (WN)2 in R2's room with concurrent observation of the placement of R2's oxygen nasal cannula on her face. WN2 identified that R2's nasal cannula was pressing into her right cheek. She lifted the cannula and confirmed there was an indentation mark and blanchable redness caused by the cannula pressing into the R2's skin. WN2 stated that what she observed was a risk for development of pressure ulcers. WN2 stated that she was unsure if there was a specific protocol to check skin integrity when a resident was wearing an oxygen nasal cannula, but checks should have been done and the skin integrity change reported. On 04/09/26 at 09:55 AM, interviewed Director of Nursing (DON) in his office. DON stated that the facility does not have any specific protocol to check the oxygen nasal cannula placement when a resident is wearing it. DON stated that the ears and cheekbones are high risk areas for development of pressure injuries and should be checked and identified when a resident is using an oxygen cannula.

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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. Based on observations, interviews, and record review, the facility failed to implement infection prevention and control measures when providing care for residents. The facility did not ensure that staff wear applicable personal protective equipment (PPE) when providing care to two of 11 residents on Transmission Based Precautions (TBP). This deficient practice placed the residents at risk for the potential spread of preventable infections and communicable diseases. Findings include:1) On 04/07/26 at 08:26 AM, observed signage by the door of Resident (R)14's room with a heading that stated, Contact Precautions. Resident (R)14 was lying in bed with a tablet computer on the table in front of her. At 08:28 AM, observed Activity Assistant (AA)5 at R14's bedside without a gown or gloves. AA5 was helping R14 with the power cord for a tablet computer that was on the table. At 08:29 AM, AA5 was also observed leaning close to R14 when communicating since R14 was talking in a very soft voice. On 04/07/26 at 08:35 AM, queried Nurse Supervisor (NS)9 at the nurses' station regarding the sign posted outside R14's door. NS9 said R14 was on contact precaution and the sign outside her door is to make staff aware of using the proper PPEs when entering the room. 2) On 04/08/26 at 08:26 AM, observed Certified Nurse Aide (CNA)22 assisting R89 with breakfast in his room. CNA22 was seated next to R89's bed and was not wearing a gown or gloves. At 08:27 AM, Registered Nurse (RN)12 confirmed that R89 was one of the residents on contact precautions as indicated by the poster at the entrance of the room. On 04/08/26 at 03:07 PM, an interview was conducted with the Infection Preventionist (IP) in her office. IP confirmed that staff are to a wear gown and gloves when providing care to residents on contact precautions. 3) On 04/09/26 at 08:51 AM, observed CNA29 assisting R89 with his meal in his room. CNA29 was not wearing a gown or gloves and was sitting next to R89. At 08:51 AM, NS9 confirmed that R89 was still on contact precautions and staff are to wear gown and gloves when providing care. Review of facility policy titled Isolation - Categories of Transmission-Based Precautions dated September 2022, stated, . Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact . Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room .