STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ka Punawai Ola	91-575 Farrington Highway Kapolei, HI 96707

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the physician when one Resident (R) 10 of three sampled for hospitalizations, had an acute change in condition that resulted in a transfer to the Emergency Department (ED). Findings include: Cross reference to F684 Quality of Care. Review of R10's Electronic Health Record (EHR) on 04/22/26. R10 was admitted to the facility on [DATE] for diagnosis including severe anemia dependent on blood transfusions. 03/01/26 04:37 Type: Health Status Note. Resident to be admitted to Hospital for septic Shock. Signed by RN36.Care plan reviewed. Focus. R10 is at risk for rehospitalization due to chest pain, shortness of breath (SOB) and acute pneumonia and other comorbidities revision 02/23/26. Interventions. Staff to provide timely communication to physician/ Nuse Practitioner (NP) regarding any change in resident condition. 02/05/26.An Interview and record review was conducted with the Director of Nursing (DON) on 04/23/26 at approximately 12:30 PM in the surveyor conference room. The surveyor asked the DON to review the documentation in the EHR to find the notes about R10's change in health status when she declined on 02/28/26. The DON looked in the EHR and confirmed there was no documentation that stated R10 declined, the doctor was notified of R10's condition, or that R10 was sent to the ER.An Interview with the Advanced Practice Registered Nurse (APRN) 5 on 04/24/26 at 11:00 AM at the [NAME] nurses station. Asked him if the nurse called him to inform him of R10's decline and transfer to the and said they may have called the on-call practitioner since it was on the weekend.During a Telephone interview with Registered Nurse (RN) 24 on 04/24/26 at 12:30 PM to discuss R10, asked RN24 if she called the doctor or APRN on 02/28/26 when R10 wasn't feeling well to report R10's change in condition. RN24 said she couldn't remember.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to develop a comprehensive care plan that was individualized to address the needs for one of three residents (Resident (R), 30) to prevent falls and failed to implement the use of floor mats for one of three residents, R20 investigated for falls.Findings Include:1) On 04/21/26 at 09:00 AM, review of R30's electronic health record (EHR) noted that R30 is an 87-year male admitted to the facility on [DATE] with a diagnosis of but not limited to hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side, muscle weakness, difficulty walking, heart failure, and diabetes. R30 prior to being admitted to the facility had two falls at home requiring hospitalization where he initially started physical therapy treatments (PTT) and continued with strength and conditioning at the facility. Cross reference to F689. a)On 04/21/26 at 09:00 AM, review of R30's physician orders included Fluid Restriction: 1500 ml (milliliters)/day, with a start date of 01/31/26, TED Hose to bilateral legs; on in am, off in PM one time a day for EDEMA and remove per schedule, which was ordered on 02/04/26 could not be found in the care plan.b) On 04/21/26 at 09:10 AM, review of the facility's initial fall risk assessment noted that R30 had moderately impaired vision, however, there was no care plan found to address visual impairment.c)On 04/21/26 at 09:30 AM, review of the facility's Incidents by Incident Type Listing from 02/01/26-04/22/26 and the fall incident reports provided by the facility noted that R30 had three witnessed falls and one near fall incident resulting in skin injury. The first fall on 02/03/26 at 03:40 PM, which was witness by staff was due to one of the wheels on the R30's wheelchair not locked. The second fall on 02/26/26 at 11:00 AM was unwitnessed and the cause of the fall was determined that R30's knees gave out when attempting to get on his wheelchair. The third fall that happened on 02/26/26 at 08:05 AM, was a witnessed fall and R30's legs gave out, while CNA was helping him. The fourth fall occurred on 02/28/26 at 07:10 AM, a witnessed fall where R30 lost his balance and twisted his ankle, while being helped in the bathroom by a CNA, resulting in major injury and requiring hospitalization and surgery. The near fall incident happened on 02/22/26 were a CNA reported that as they were trying get R30's weight, R30's leg buckled which caused him to lose balance and scrape his left knee and stub his left great toe on the wheelchair. On 04/21/26 at 10:00 AM, review of R30's care plan noted the following:Focus: RISK FOR FALLS: R30 is at risk for falls as evidenced by fall risk present as determined by fall risk evaluation with a score of > 10 on admission. Functional problem: presents with balance deficits and strength impairments and in consideration of history, personal factors, and functional limitations, with s/p (status post) fall at home, leading to dx (diagnosis) of intraparenchymal hemorrhage-right occipital, left cerebellum, with history of DM (diabetes), HTN (Hypertension), HfpEF (Heart failure), A. Fib (Atrial Fibrillation).this focus was initiated on 01/19/26 and revised on 02/04/26.Goal: R30 will not sustain serious injury requiring hospitalization through the review date. Goal was initiated on 01/19/26 with a revised date of 02/07/26, with target date of 04/19/26.Interventions/Tasks: Assist with ADLs (Activities of daily living as needed)-initiated on 01/19/26Call light within reach-initiated on 01/19/26Complete fall risk assessment-initiated on 01/19/26Encourage toileting prior to bedtime and encourage/offer to toilet if see up at night- initiated on 02/11/26.Increase diuretics to decrease swelling to lower extremities-initiated on 02/27/26Orient resident to room-initiated 01/19/26Place sign at bedside as reminder to R30 to use the call light and wait for assistance prior to ambulation/transfers-initiated on 02/03/26ST screen to address cognition-initiated on 02/04/26There was no nursing intervention to address the wheelchair being unlocked or any interventions to address environmental hazards. The care plan did not include additional interventions to address R30's memory impairment, i.e. hourly rounding, sitting or close monitoring, or safety checks. Nursing interventions to address R30's continued LE edema, weakness, unsteady gait, legs giving out, and the need for adequate staffing to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meet the R30's needs were not developed.04/23/26 at 11:00 AM, interview with the DON acknowledged that R30's care plan could have been more comprehensive and individualized to address R30's ongoing and increasing needs.2) R20 is an [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of but not limited to left knee idiopathic gout, moderate-protein calorie malnutrition, muscle weakness, dysphagia and cognitive communication deficits. On 04/21/26 at 09:30 AM, review of the facility's Incidents by Incident Type Listing from 02/01/26-04/22/26 noted that R20 had two unwitnessed falls, 04/15/26 at 12:15 PM and 04/18/26 at 12:20 AM.On 04/21/26 at 10:00 AM, review of R20's care plan noted Focus: At risk for falls r/t (related to) deconditioning and functional dependence s/p hospitalization. Goal: The resident will not sustain serious injury requiring hospitalization through review date. Interventions: Bilateral fall mats when in bed, call light and frequently used items within easy reach, assist with ADLs (Activities of daily living) as needed, and completed fall risk assessment.On 04/24/26 at 10:30 AM, observed R20 asleep in bed with bed in low position, but with no fall mats on the bedside floor. The fall mats were flushed against the wall in front of the entrance of R20's room. On 04/24/26 at 01:10 PM, interview with DON acknowledged that the floor mats were not in the right place and it does not do the resident any good having it flushed against the wall. On 04/24/26 at 02:00 PM, review of the facility's Comprehensive Care Plan and Revisions policy, with reviewed date of 08/29/25, in the Policy section, it reads, The facility will ensure that the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team who has the knowledge of the resident and his/her needs. In the Procedure section, it states 1. The facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered care plan.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to identify and intervene for an acute change in a resident's condition related to infection for one Resident (R) 10 resulting in R10's family member initiating the transfer to the Emergency Department. The resident was admitted to the hospital with respiratory distress, pulmonary edema, and septic shock. There was no documentation of the resident's vital signs or notification of the change in condition to the physician which preceded the transfer to the Emergency Department, cross reference to F580. The deficient practice caused harm to the resident related to complications of sepsis. Findings include: Intake #2968720 reviewed on 04/21/26. R10's Family Member (FM) contacted the Office of Healthcare Assurance (OHCA) about an incident that occurred on 02/28/26 when R10 had a change in her condition that resulted in a transfer and admission to the hospital. R10's FM stated that R10 had a big bed sore that was identified on 02/27/26 and was told that R10 got it from an acute care facility the previous day when she went to have a blood transfusion on 02/26/26 where she sat for 5 hours. The FM stated no nurses told her about the bed sore. The FM said on 02/28/26 the Speech Therapist approached and told the FM that R10 was very weak that day. The FM wanted R10 to be sent to the ER due to her poor condition, and that the facility did not report that R10's status had changed and she was weak. The facility staff told her that R10 was cold that day asked for extra blankets. The FM demanded that her mom be sent to the ER. When the ambulance came and took R10's temperature she had a fever. R10 was taken to the ER after 5 PM on 02/28/26. R10 had a pressure ulcer that was 10 centimeters (cm), (a photo of the pressure ulcer was provided from the FM), and she was diagnosed with septic shock. The FM stated that R10 passed away on 03/08/26 in the hospital. Review of R10's Electronic Health Record (EHR) on 04/22/26. Resident (R10) is an [AGE] year-old female admitted to the facility on [DATE] for rehab services after a hospitalization. R10 had a seven percent (%) weight loss identified on 02/18/26 and acquired an unstageable pressure ulcer to the coccyx on 02/27/26. R10's diagnosis includes anemia (low red blood cells) requiring blood transfusions; difficulty in walking; muscle weakness; dysphagia (difficulty swallowing) and primary hypertension. R10 was transferred to the Emergency Department (ED) on 2/28/26 for high fever and heart rate and diagnosed with Sepsis. Minimum Data Set (MDS) discharge return anticipated with an Assessment Reference Date (ARD) of 02/29/26 reviewed. R10 requires substantial/maximal assistance with eating and was unable to ambulate or sit to stand. R10 had weight loss and was not on a prescribed weight loss regiment. R10 had one unstageable deep tissue injury to her coccyx that was identified on 02/27/26 the day before she was transferred out to the ED.Progress notes reviewed. 02/28/26 14:31 Skilled Note. Temperature (T) 97.5 02/28/26 07:19 Pulse (P) 90 02/28/26 07:19 Blood pressure (BP) 102/51 02/28/26 07:19 pain level 6 02/28/26 13:34 Pain scale: Numerical.No adverse effects noted on shift.On continous (sp) oxygen via nasal cannula 2 liters per minute (LPM) sating 93% and above; no SOB noted on shift.Signed by Registered Nurse (RN)28.02/28/26 17:07 Type: Orders - Administration Note. Acetaminophen Tablet 325 milligram (MG) Give 2 tablet by mouth every 4 hours as needed (PRN) for pain Acetaminophen. PRN Administration was: Unknown hospitalized . Signed by RN24.03/01/26 04:37 Type: Health Status Note. Resident to be admitted to Hospital for septic shock. Signed by RN36.Progress notes of R10's change in health status, with R10's vital signs and communication to the physician prior to the transfer to the hospital on [DATE] were not available for review in the EHR. The last vital signs that were documented were on 02/28/26 at 07:19 AM. eINTERACT (electronic) Transfer Form dated 02/28/26 reviewed. B. Transfer Details. 1. Sent To: Hospital listed was not the correct hospital. It was called in to EMS on 02/28/26 at 17:30 by RN24. The vital signs documented on the form were from the morning on 02/28/26 at 07:19 AM. An interview and record review was done with the Director of Nursing (DON) on 04/23/26 at approximately 12:30 PM in the surveyor conference room. The surveyor asked the DON to review the documentation in the EHR and look for (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	information about R10's health status, when and why R10 was transferred to the ER. The DON looked in the EHR and confirmed there was no documentation that stated R10 declined and the doctor was notified of R10's condition or that the resident was sent to the ER. Asked the DON if there is a transfer/ discharge summary in the EHR with documented status date/ time, when resident was transferred, Doctor was notified, and family/ representative was notified. The DON looked in the EHR and said, there is a transfer/ discharge summary, but it's blank and confirmed there was nothing written to indicate when the resident went to the ER and the reason why. Asked the DON where the information about a resident's discharge/ transfer should be documented. The DON stated that the information should be documented in the progress notes and confirmed the notes were missing. Asked the DON if there is documentation that the vital signs were taken at the time R10 declined. The DON confirmed the vital signs were missing. An Interview and concurrent record review was conducted with the RN Supervisor (RNS) on 04/24/26 at 10:59 AM in the surveyor conference room. The surveyor asked RNS to discuss what occurred on 02/28/26 when R10 declined. RNS said it was on the evening shift. The Speech Therapist (ST) came to the desk and asked me to check on R10, and that she wasn't looking very good. I asked the evening nurse who was assigned to R10 if she had seen R10 and if she would go check on her. I went to check R10 with the ST. When I saw R10 she seemed ok. The FM came to me and said R10 isn't doing well, and this wasn't her baseline. We discussed that R10 wasn't eating well for the past few days, and the FM asked if R10 was getting fluids and felt like she needed more fluids. The FM asked what we do now and I told her we can call the doctor and offer her intravenous (IV) fluids. The FM said she wanted R10 to go to the ER. When asked what the vital signs were that day, she said she didn't remember. The RNS said she talked to R10's nurse, RN24 and she was new, she asked her if R10's family shared concerns about R10 and she said they did and she was going to go back to assess R10 but then she got busy with another resident and forgot to check back on her. RN24 went and did her assessment for R10, and the family insisted on taking her to the hospital. I think RN24 called the doctor to inform him. When asked the RNS what happens if there is a change in condition, she said, we inform the doctor then we implement our interventions and do our assessment and carry out any orders. Everything that happens gets documented in the progress notes, she looked in the EHR and said that she didn't see any notes documented there. Telephone interview with RN24 on 04/24/26 at 12:30 PM. Asked RN24 if she was assigned to R10's care on 02/28/26 and confirmed that she was assigned to her. Asked her to describe what happened on 02/28/26 prior to R10 transferring out to the ER. RN24 said she had just started her shift and the RNS came to her saying the family had concerns about the resident that she was very warm and wasn't feeling well. When she went to check R10, she felt warm, so she checked her temperature and it was 101 degrees. Her heart rate was also high, but she didn't remember what it was. RN24 said the family was there and they wanted R10 to go to the ER. The RNS and other staff helped get the paperwork together to send her out. Asked RN24 if the doctor was called to report the resident's fever. RN24 said she couldn't remember if she called the doctor and when asked if she documented the temperature and vital signs. She said she was busy and forgot to document the resident's vital signs. Asked her if she received report from day shift nurse she said yes, she did and they didn't report anything wrong with the resident, and everything was fine. Review of R10's hospital records on 04/24/26. ED Provider notes dated 03/01/26 at 1627 reviewed on 04/24/26. Diagnostic Impression: Pneumonia, bacterial Septic shock. Disposition: Admit. Chief complaint: Shortness of breath (brought in by ambulance from care at facility, staff states desaturation (low oxygen to the tissues) 88-89% generalized edema (swelling), shortness of breath.Tylenol given by staff prior to admission as per triage nurse.Vital signs Temp: 100.5, pulse 123, respirations 35 BP: 1-3/55, Saturation 93% on oxygen (O2). Hospitalist admission History and Physical (H&P) notes reviewed. In ER patient was found to be initially normotensive, tachycardic, and mildly febrile (normal blood pressure, high heart rate and fever) .Developed hypotension (low blood pressure) on monitor during my evaluation. I was asked to admit the patient for septic shock. BP 92/49, Pulse 93, Temp 99.4 Resp (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	23.large sacral decubitus ulcer (bed sore).2) EHR reviewed on 04/24/26. Progress notes reviewed. Type: Nutrition/ Dietary Note Date: 2/25/2026 14:39:13 Note Text: Resident with 7.0% significant weight (wt.) loss x 30 days likely related to poor oral intake mostly 0-50% with occasional refusals. Diet order: Reg, EC7 (easy to chew), Thin (liquids) with no added salt. ONS (on nutrition supplement): Med Pass 60 ml BID (twice per day) (takes 100%). Per resident appetite varies depending on the meal. Registered Dietician (RD) requested ST to determine if resident's texture can be upgraded to get the choice menu. The RD increased 90 ml three times per day (TID) & added orders to offer snacks TID. MD notified. Dietary care plan reviewed. Focus. At nutrition and hydration risk related to current health status including severe anemia.initiated 02/09/26. Interventions.Weekly weights x 4 weeks. Assistance with meals as needed.Weights reviewed: 02/05/26 13:30 138.0 lbs. Hoyer lift. 02/18/26. 17:23 128.5 lbs. Hoyer lift Resident had a significant weight loss of 7.2 % in 13 days. Telephone interview on 04/28/26 at 10:32 AM with Dietary Manager (DM) 2 Asked what interventions were in place prior to R10's weight loss. The DM2 said she was on a Liberalized (unrestricted) cardiac 2 Gram (GM) diet with no salt packets for fluid imbalance and edema. Asked the DM2 when the weight loss was identified. The DM2 said after she was admitted , the weekly weight didn't get done, there were weights done on 02/05/26 and 02/18/26. The DM1 was on leave until the 16th, and I stopped covering R10 on the 13th. It was hard for her to get out of bed, and she required a Hoyer lift. Once the DM1 discovered the weight loss, she added 2 Cal med Pass (a supplement) on the 16th and started the pro T gold 17 gm per 30 milliliters (ml), a supplement on the 27th when the pressure ulcer was identified.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to implement and develop interventions to prevent avoidable falls for one of three residents (Resident (R), 30) investigated for falls. R30 had four fall incidents ([DATE], [DATE], [DATE], [DATE]) and one near fall incident ([DATE]) from the time he was admitted to the facility on [DATE]. This deficient practice has the potential to affect residents with balance deficits and strength impairments.Findings Include:Cross reference to F656On [DATE] at 08:00 AM, the Department of Health, Office of Health Care Assurance (OHCA) received a complaint from R30's Family Member (FM) 2 that R30 sustained three falls at the facility. The FM2 stated that R30 was admitted to the facility on [DATE] and was going through rehab, working with therapist to strengthen his legs which never quite healed. The FM2 noted that for the first fall incident, R30 was able to crawl to the wheelchair before the staff got to him. The FM2 stated the second fall happened the same month but could not recall the specific dates and times, but R30 was working with the therapist when the fall happened. The FM2 recalls the third fall incident happened on [DATE] when a Certified Nurse Assistant (CNA) was helping him to the restroom but fell again and ended up fracturing his left ankle which required R30 to be transferred to the hospital for surgery and has been there since. The FM2 also mentioned that R30 injured his heel with one of the falls, with the heel getting infected and never healed. The FM2 stated that since R30's fall incidents, he has been going downhill and is now on comfort measures only. The FM2 stated that she was informed each time R30 fell and spoke with a Registered Nurse (RN) of what happened and what they were going to be doing to prevent further falls but felt that the facility may not have changed their processes to have prevented subsequent falls. On [DATE] at 09:00 AM, review of R30's electronic health record (EHR) noted that R30 is an 87-year male admitted to the facility on [DATE] with a diagnosis of but not limited to hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side, muscle weakness, difficulty walking, heart failure, and diabetes. R30 prior to being admitted to the facility had two falls at home requiring hospitalization where he initially started physical therapy treatments (PTT) and continued with strength and conditioning at the facility. Review of the nursing admission assessment completed on [DATE] noted that R30's reason for admission was for rehabilitation and oral antibiotic therapy treatment, to include PTT and OT (Occupational Therapy). R30's cognition assessment on admission on ly notes that he had a hearing impairment and was oriented to person, place, and time, with primary means of communication to be verbal and can understand others and make himself understood. R30 was noted to have 3+ edema to left arm, none documented for lower extremity (LE) edema. R30 was continent for urinary status, however, needed extensive assistance for transfers, toileting, personal hygiene, and dressing. R30 was noted to require limited assistance with ambulation and/locomotion, but was found to have gait disturbance, unsteady gait, and balance issues due to right LE weakness. R30 had multiple skin condition with abrasion to bilateral knees and dorsum of left foot and right foot 2nd toe. R30 was noted to be a fall risk alert and review of R30's initial fall risk assessment on admission noted R30's mobility status was confined to chair and balance marked as not able to attempt test without physical help. R30 was also noted to have moderately impaired-limited vision but can identify objects, and R30's continent status was marked as elimination with assistance, which meant he was continent but needed assistance to use the bathroom.On [DATE] at 09:30 AM, review of the facility's Incidents by Incident Type Listing from [DATE]-[DATE] noted that R30 had three witnessed falls. The first fall was on [DATE] at 03:40 PM, the second fall on [DATE] at 08:05 AM, and the third fall at [DATE] at 07:10 AM. R30 was also listed as having one unwitnessed fall on [DATE] at 11:20 PM and a skin related injury on [DATE] at 11:00 AM. On [DATE] at 09:30 AM, a review of the fall incident reports that were provided by the facility was completed and with the following findings:1) Fall #1 was an (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	unwitnessed fall, that happened on [DATE] at 15:40 PM in R30's room. This incident report was reported by RN1. The incident description is as follows:Nursing description: R30 opened his door, yelling Hey! RN1 went to check on resident, R30 was trying to sit back on his wheelchair, one wheel was not locked, and R30 fell on his bottom.Resident description: R30 stated, she told me she was going to get it ready so I can go to bed. RN1 explained it was too early for bed, R30 apologized and said he thought it was bedtime.Immediate action taken: RN1 helped R30 off the floor with CNA's assist. R30's vitals were wnl (within normal limits). R30 denied pain. A fall huddle was completed with new interventions put into place: Place sign at bedside as reminder to R30 to use call light and wait for assistance prior to ambulation/transfers, ST (short test of mental status) screen to address cognition.Injuries observed at time of Incident: No injuries observed at time of incidentMental Status: Oriented to Person/PlacePredisposing factors: OtherPredisposing physiological factors: Recent illness, gait imbalancePredisposing situation factors: Ambulating without assistOn [DATE] at 09:45 AM, review of the fall risk evaluation form completed on [DATE] for this fall noted R30's mobility status marked as ambulates without problems and with devices, balance marked as unsteady, but able to rebalance without physical support, continent status was now independent and incontinent, and visual status was marked as moderately impaired-limited vision, but can identify objects.On [DATE] at 10:00 AM, review of R30's care plan, cross reference to F656.There was no nursing intervention to address the wheelchair being unlocked or other interventions to address environmental hazards (i.e. bed in low position) noted in care plan with this fall incident. There was also no care plan found to address R30's moderately impaired vision (i.e. adequate lighting)On [DATE] at 11:00 AM, interview with the Director of Nursing (DON) completed. When asked about what the other was for the predisposing factor, DON noted that it could be the wheelchair but needed to confirm with RN1. DON acknowledged that the care plan should have been revised to include having the wheelchair locked and secure to prevent further falls/accidents and to address R30's visual impairment. On [DATE] 08:40 AM, interview with RN1 confirmed the fall incident on [DATE] and stated that R30 was calling for help and was able to open the door. R30 was confused about the CNA getting him something ready for bed and RN1 had to explain to R30 that it was too early for bed. RN1 further noted that R30 was able to walk back to his wheelchair to sit down but fell on his buttocks due to one of the wheels on wheelchair being unlocked. RN1 acknowledged that it is everyone's responsibility to ensure that the wheels are locked to prevent accidents. RN1 confirmed that locking the wheelchair was missed and the fall could have been prevented. RN1 also confirmed that the predisposing factors marked as other on the incident report was the wheelchair.On [DATE] at 09:00 AM, review of the physical therapy treatment (PTT) progress notes for dates of service from [DATE]-[DATE] indicated that for balance, R30 can stand unsupported with AD (assisted device) for 10 seconds. R30 was also noted to have a Tinetti balance (a health tool that screens elderly patients for balance and gait) score of 10/16, gait score of 9/12, for total score of 19/28, which indicated R30 had an increased risk of falling. R30 also had a mobility function score (ranges from 0-12; 12 being the highest function) of six, which indicates that R30 was generally dependent on mobility maneuvers and required help with basic ADLs (Activities of daily living) such as transfers, toileting, and dressing. 2) Fall #2 was an un-witnessed fall on [DATE] at 23:20 PM in R30's room. This report was prepared by RN2. The incident description is as follows:Nursing Description: RN2 was notified by CNA1 that resident fell. RN2 went to R30's room and found R30 lying on the floor, bed noted in lowest position. RN2 noted a bump on the occipital area and skin tear on R30's left rear upper arm, cold compress then applied on the bump and wound dressing done on the skin tear, no other injuries noted, denied pain. R30 is oriented to self, time, and situation (baseline). RN2 notified FM and MD (medical doctor).Resident Description: R30 verbalized, I feel so bad, I always use the call light but now I didn't. I wanted to go to the bathroom, so I got up to get to my wheelchair then my knees just gave out and then I hit the back of my head.Immediate Action Taken: Fall prevention sign placed on R30's room, brought R30 to the bathroom, made sure bed is in lowest position. Fall huddle complete with fall interventions added: Encourage toileting prior to (continued on next page)

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	125051	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ka Punawai Ola	91-575 Farrington Highway Kapolei, HI 96707

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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 0689 Level of Harm - Actual harm Residents Affected - Few	bedtime and encourage/offer to toilet if see up at night.Injuries Observed at time of incident: No Injuries observed at time of incident (this is inconsistent with the nursing description).Mental Status: Oriented to person/situation/timePredisposing Physiological Factors: Gait Imbalance, Impaired MemoryPredisposing Situation Factors: Ambulating without assistanceOn [DATE] at 09:45 AM, review of the fall risk assessment completed on [DATE] for this fall noted R30's mobility status marked as ambulates with problems and with devices, balance marked as unsteady, but able to rebalance without physical support.Care plan review noted it did not include bed in low position as noted in the nursing description and no additional interventions to address impaired memory (i.e. hourly rounding, close monitoring)XXX[DATE] at 11:00 AM, interview with the DON noted that the bed in low position was not included to the care plan and frequent monitoring should have been implemented. 3) On [DATE] at 01:30 PM, review of R30's progress notes detailed a near fall incident that happened on [DATE] at 11:00 AM. A health status note was created by RN5, which read that CNA reported that as they were trying get R30's weight, R30's leg buckled which caused him to lose balance and scrape his left knee and stub his left great toe on the wheelchair, but the CNA was able to guide R30 back down to the wheelchair. RN and Unit Manager (UM) were made aware of the incident. Upon assessment, R30 had a skin tear to his left knee and left great toe.4) Fall #3 was a witnessed fall that happened in R30's room on [DATE] at 08:05 AM. This incident was reported by RN3. The incident description is as follows:Nursing Description: RN3 found patient sitting on the floor to his left side of his bed (witnessed fall by CNA), per CNA on duty, she assisted patient pulling R30's shorts up while standing, went to turn to pivot to R30's wheelchair then R30 grabbed CNA's shoulder and at that time R30's legs gave up. CNA assisted him slowly on the floor and R30 did not hit his head, and no new injury was noted.Resident description: R30 stated My legs gave up.Immediate Action Taken: R30 was put back to bed with three person assist, with no new injuries. MD and RP (resident representative) were notified. A new order from MD to increase Lasix to 20 mg (milligram) bid (twice a day) x7 days then 20mg daily for edema to his legs. Intervention: Change in diuretic medication to reduce swelling which is affecting R30's ability to stand and transfer to wheelchair.Injuries observed at time of incident: No injuries observed at time of incident.Mental Status: Oriented to person (this was a decrease in mental status in comparison to previous fall incidents)Predisposing Physiological Factors: Incontinent, Recent Illness, Weakness/Fainted, Gait Imbalance, Impaired MemoryOn [DATE] at 10:15 AM, review of the physician's orders noted TED (Thrombo-Embolus Deterrent) Hose to bilateral legs; on in am, and off in PM one time a day for edema and remove per schedule. R30 was also ordered fluid restriction of 1500ml/day starting on [DATE]. On [DATE] at 10:15 AM, review R30's care plan did not include the TED hose to bilateral legs application, the fluid restriction of 1500ml per day, or any nursing interventions to address LE edema. There was also no nursing interventions started to address R30's memory impairment, continued leg weakness, and gait imbalance. This was R30's second fall and third incident of his legs giving out and needing more than one person to assist him back to bed. No interventions or discussion noted that R30 would have benefitted from having two staff to assist him with ADLS due continued LE weakness and unsteadiness.On [DATE] at 10:30 AM, review of the fall risk evaluation completed for fall incident on [DATE], noted R30's mobility status marked as confined to chair, balance marked as Not able to attempt test without physical help.[DATE] at 11:00 AM, interview with the DON confirmed that TED hose application, fluid restriction, and other measures to address his LE weakness and knee buckling should have been included as it directs the resident's care and treatment. 5) Fall # 4 was a witnessed fall in resident's bathroom on [DATE] at 07:10 AM. This incident was reported by RN4. The incident description is as follows:Nursing Description: At about 07:08 AM, RN4 heard the CNA calling for help. Upon arrival at the room, R30 was sitting on the floor with his back by the CNA's legs. R30's left foot is against the wall. RN4 noticed blood on the floor, moved the foot to straighten and saw an open wound by the ankle joint. Per interview with the CNA, she was with R30 in the bathroom to do a brief change. R30 was holding onto the railing and was standing, with wheelchair locked and placed behind (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	him. While R30 was standing, CNA pulled down R30's shorts and removed the soiled brief. R30 was still standing and lifted one leg as CNA inserted one hole of the new brief. When R30 put his leg down, that was when the fall happened. CNA was able to catch R30's head as he fell on his buttocks area. CNA felt the wheelchair push to the side. CNA then called for help and the nurse came. That is when they saw the fracture on R30's ankle. They called 911.Resident description: R30 stated he lost his balance and twisted his ankle.Immediate Action Taken: The weekend supervisor was informed and the facility called 911. While waiting, R30 was laid on the floor and started on 02 (oxygen) at 2LPM (liters per minute) with 96% 02 saturation. Vital sign taken: Temperature-97.8, Pulse 89, Respiration 20, and BP (blood pressure) at 106/66. R30 was transported via gurney and left at facility around 07:55 AM. R30 was brought to the hospital. MD was informed at 07:52 AM and approximately at 07:50 AM, FM was called 3x but there was no answer and mailbox was full. According to CNA, she took care of R30 before, and she was assisting R30 like how she does when she cares for him. R30 had prior falls related to buckling. In the ER (emergency room), R30 reported that he lost his balance and twisted his ankle. R30 was found to have a left open distal tibia and fibula fracture. R30 underwent left tibia and fibula reduction and remains in the hospital.Injuries Observed at time of Incident: Fracture, left inner ankleLevel of pain: 10.Mental Status: Oriented to Person/PlacePredisposing Physiological Factors: Incontinent, Recent Illness, Weakness/Fainted, [NAME] Imbalance, Impaired memoryPredisposing Situation Factors: Level 3 (individual-level risk factors)On [DATE] at 10:30 AM, review of the fall risk evaluation completed for the [DATE] fall noted R30's mobility status marked as ambulates with problems and with devices and balance marked as not able to attempt test without physical help.On [DATE] at 09:00 AM, review of the PTT summary of functional progress from 02/24-03/16 noted that R30 was downgraded (resident had plateaued) and was not able to make any more improvements in the areas of transferring and gait. The status of R30's ability to transfer and gait remained at supervision or touching assistance. Tinetti score of 21/28, although improved from initial baseline, remained as increased fall risk. Review of the PTT notes dated [DATE], a day prior to the [DATE] fall, R30 was found to have a pain intensity level of 5/10, with constant frequency to the right hand, right ankle, and right groin post therapy. It was also noted that R30 required extra time to process new information with this session. On [DATE], R30 had a PTT after the fall and post treatment results noted that R30 had a 6/10 pain intensity level with constant frequency to bilateral ankles. R30's response to treatment was met with unsteadiness on bilateral knees with knee buckling during transfer just before sitting. The PTT on [DATE] noted that R30's knee buckled again and R30 had to sit down. PT1 discussed with FM, R30's mobility level and recommended R30 to have 24-hour care at this time. R30's response to this PTT noted increased unsteadiness while standing with two episodes of knees buckling while standing.On [DATE] at 12:30 PM, interview with PT1 stated that they are aware of the residents' fall as they get a printout each day. They will take extra precautions and modify the treatment session considering the fall incident. PT1 was aware of R30's four fall incidents and noted that R30 made progress with treatments but later plateaued and could no longer improve in certain areas (gait and transferring) due to various factors to include, pain, skin issues, and the different medical conditions R30 has. When asked if R30's falls could have been prevented, PT1 stated that it is hard to predict when the fall is going to happen but stated that the CNAs should be knowledgeable and trained to assist residents with gait and balance issues to prevent the falls. When asked about how they communicate with nursing staff of any pertinent information that happened with residents during the PTTs, PT1 noted that they have daily rounds in the morning that is attended by nursing staff and the Director of Rehabilitation (DOR) but states the PT staff do not attend. When asked if he communicated R30's post-treatment response to PTTs regarding his pain intensity on [DATE], regarding increasing pain intensity level, unsteadiness on bilateral knees, and buckling during transfer on [DATE], regarding increased unsteadiness while standing with two episodes of knee buckling while standing on [DATE], and recommendation to have R30 with 24-hour, PT1 could not recall if he did. PT1 did acknowledge that this is significant information to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	communicate to nursing staff.On [DATE] at 01:10 PM, interview with DON noted that their primary means of communication with other departments is the daily grand rounds. The daily grand rounds are held Monday-Friday in the morning and the DOR attends and will present a list of concerns they may have with residents. When asked if the R30's pain level and increased unsteadiness and episodes of knees buckling during his therapy sessions on [DATE]-[DATE] was communicated to the nursing department, DON verbalized she did not remember it being presented in daily rounds. DON acknowledge that it should have been communicated right away so that appropriate nursing interventions could have been implemented and extra precautions made to prevent further falls. When discussing the plan of care revisions after this incident, DON noted that R30 expired about two weeks ago.On [DATE] at 02:00 PM, review of the facility's Fall Management policy with a reviewed date of [DATE], it states in the Policy section, The facility will assess the resident upon admission, quarterly, with change in condition, and with any fall event for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls. In the Avoidable Accident section, it reads, 1. Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices. 3. Implement interventions, including adequate supervision.consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident. 4. Monitor the effectiveness of the interventions and modify the care plan as necessary in accordance with current professional standards of practice. Risk-Refers to any external factor, facility characteristics (i.e. staffing or physical environment) or characteristics of an individual resident that influence the likelihood of an accident. Supervision/Adequate supervision refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of staff, and the frequency of supervision needed. The determination is based on the individual resident's assessed needs. In the Procedure section, it states 4. The interdisciplinary team will review and revise the care plan, if indicated, upon completion of each comprehensive, significant change.upon a fall event and as needed thereafter.6. The interventions to reduce the risk of falls should be individualized based on the resident risk factors and fall history. One of these interventions may include safety checks.