STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125055	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hi'Olani Care Center at Kahala Nui	4389 Malia Street Honolulu, HI 96821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48351 Based on interviews and record review, the facility failed to provide written notification to resident or resident's representative and the Long-Term Care Ombudsman (LTCO) forone of one sampled residents for hospitalization s, (Resident (R) 13). This deficient practice has the potential to affect all residents that are transferred to an acute care hospital. Findings Include: R13 is a [AGE] year-old female who was transferred and admitted to the hospital on 3/16/24. A review of R13's Electronic Health Record (EHR) was conducted, and it did not contain any documentation that R13's family representative and the LTCO was provided with a written notification of R13's transfer to an acute care hospital. Interview was conducted on 06/26/24 at 01:44 PM with Social Worker (SW) 1. SW1 stated that during a transfer to the hospital, the nursing staff calls the resident's family and informs the representative that the resident is being transferred to the hospital. SW1 added that a written notification of the resident's transfer to the hospital is not provided to the resident's representative and the LTCO. Interview was conducted on 06/26/24 at 02:09 PM with the Director of Nursing (DON). DON stated that during a resident's transfer to the hospital, a phone call is made to the resident's family by the nursing staff. DON confirmed that a written notification is not provided to the resident's representative and the LTCO during a resident's transfer to the hospital. A review of the facility records titled, Discharge/Transfer of the Resident, dated April 22, 2024, was conducted. The record documented, Explain transfer and reason to the Resident and/or representative and give copy of signed transfer or discharge notice to the Resident and/or representative or person(s) responsible for care. (NOTE: If an emergency transfer occurs, the Transfer or Discharge Notice form may be completed later, but as soon as possible).

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
	125055	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hi'Olani Care Center at Kahala Nui	4389 Malia Street Honolulu, HI 96821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 48351 Based on interviews and record review, the facility failed to implement a comprehensive person-centered care plan for one of 16 sampled residents (Resident (R) 168). This deficient practice has the potential to negatively affect the resident's physical and overall well-being. Findings Include: R168 is a [AGE] year-old female admitted to the facility on [DATE]. R168 has a medical history including, but not limited to dementia, kidney disease, and poor food intake by mouth. A review of R168's Electronic Health Record (EHR) was conducted on 6/24/24. R168's EHR contained information on her measured weights. On 05/22/24, R168's weight was 89.8 pounds (lbs). On 05/28/24, R168's weight was 89.8 lbs. On 06/04/24, R168's weight was measured 0 lbs. On 06/11/24, R168's weight was 80.0 lbs. No other weights were documented since 06/10/24. A review of R168's care plan was conducted. R168's care plan noted, Monitor weekly weights x 4 weeks (from admission) then monthly thereafter if weight is stable. Start: 05/29/24. Interview was conducted with the Director of Nursing (DON) on 06/27/24 at 10:39 AM. DON was shown R168's documented weights on the EHR. DON confirmed that the facility did not weight R168 weekly for 4 weeks, which should have been done, based on R168's care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125055	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hi'Olani Care Center at Kahala Nui	4389 Malia Street Honolulu, HI 96821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for 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** 43414 Based on observation, interview and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standard of practice for one of 16 residents sampled (Resident (R) 15). The facility did not follow the physician ordered bowel instruction. This failure could place the resident at risk of adverse consequences from diarrhea. Findings include: R15 was admitted to the facility on [DATE] with diagnoses, not limited to, weakness, presence of foley catheter for urinary retention, severe protein-calorie malnutrition, pressure ulcer of sacral region, history of sepsis, history of urinary tract infection, impaired mobility, self-care disability, and constipation. On 06/24/24 at 10:06 AM, an observation and interview with R15 was done. R15 reported he has constipation all the time and receives a suppository twice a day. R15 further reported he needs assistance when he has loose stools and makes a mess. After the interview, R15 was observed going to the restroom to have a bowel movement, inquired if he needs assistance going to the bathroom, R15 stated no and can go on his own. Review of R15's routine physician ordered bowel regimen included MiraLAX twice a day for constipation, hold for loose stool, Senna Plus twice a day for constipation, hold for loose stool, and bisacodyl rectal suppository at bedtime for constipation, hold for loose stool. R15's physician ordered bowel regimen included as needed (PRN) medications with instructions if continued constipation or by resident's request. Review of R15's daily documented bowel movement for June found R15 with bowel movements more than once, daily. R15 had documented loose stools on 06/15/24 at 05:56 AM and 10:13 AM and on 06/16/24 at 09:45 AM. Review of R15's June Medication Administration Record (MAR) documented on 06/15/24 and 06/16/24, R15 was administered MiraLAX at 08:00 AM and 05:00 PM, Senna Plus at 08:00 AM and 08:00 PM, and the Bisacodyl rectal suppository at 08:00 PM. R15's medications for constipation were not held as ordered after having loose stools on 06/15/24 and 06/16/24. On 06/16/24 at 11:55 AM, R15 was administered a PRN by resident request Bisacodyl rectal suppository although R15 had a loose stool two hours prior to request. On 06/26/24 at 11:28 AM, interview with License Practical Nurse (LPN) 4 was done. Inquired how nursing staff review residents' bowel movement status prior to administering bowel regimen related medication such as stool softeners, LPN4 was able to pull up a report from the Electronic Health Record (EHR) that showed numbers indicating what type of bowel movement was made. LPN further reported, nursing staff would look at the report by the end of every shift and inform the next shift nurse if a resident had a loose stool to ensure they do not give a resident a suppository. Inquired what 5 indicated and LPN4 reported extra-large bowel movement. Requested for LPN4 to check again what 5 indicated and reported loose stool. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125055	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hi'Olani Care Center at Kahala Nui	4389 Malia Street Honolulu, HI 96821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/24 at 11:32 AM, interview with Certified Nurse's Aide (CNA) 19, CNA 22, and Registered Nurse (RN) 5 was done. CAN 19 and CNA22 reported they do not put numbers on the record when documenting bowel movements, as shown on the EHR but describe the kind of bowel movement, by size or type, such as small, medium, large, extra-large, or loose stool. RN5 confirmed 5 indicated loose stool in the EHR. ON 06/26/24 at 02:23 PM, interview with RN5 was done. RN5 confirmed R15 had loose stools on 06/15/24 and 06/16/24 and confirmed bowel regimen medication was administered. Inquired if the medication administrating nurse should have held the medication as indicated in the physician order those days, RN5 reported she would hold the medications if the resident had loose stools the shift before. RN5 further reported R15 is very particular and adamant about having a bowel movement, however, there could be complications if he had continuous loose stools and we (the nurses) must follow the physician's order. Inquired if the resident was adamant in taking medication used for constipation although he had a loose stool, should the nurse call the physician regarding his insistence in taking the medication and document in the resident's chart, RN5 stated she will check. At 02:59 PM, RN5 was not able to provide documentation that the physician approved the administration of the medications despite the order. On 06/27/24 at 12:42 PM, interview with Director of Nursing (DON) and Assistant Director of Nursing (ADON) was done. DON reported the nurses should not go against the physician's order and to call the physician to get clarification. ADON reported if a resident had loose stools, he would hold medications as ordered by the physician and if the resident was insistent in taking the medication would get clarification from the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125055	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hi'Olani Care Center at Kahala Nui	4389 Malia Street Honolulu, HI 96821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 48351 Based on interviews and records review, the facility failed to determine that drug records are in order and that an account of all controlled drugs is maintained and reconciled for two of two medication carts sampled. This deficient practice increases the risk of diversion of residents' medications. Findings Include: A review of the facility's records titled, Controlled Drug Count Record 4th Floor Cart A, dated June 2024 was conducted on 06/25/24. The record lacked documentation of licensed nurse signatures for two shifts on 06/24/24 and one shift on 06/25/24. A review of the facility records titled, Controlled Drug Count Record 4th Floor Cart B, dated June 2024 was conducted on 06/25/24. The record lacked documentation of licensed nurse signatures for one shift on 06/15/24, and one shift on 06/16/24. Interview was conducted with the Director of Nursing (DON) on 06/25/24 at 10:20 AM. DON explained the process for controlled medications count, an outgoing nurse and an incoming nurse for the shift will count the controlled medications together. After verifying the accuracy of the count, both nurses sign their names on the facility's controlled drug count record. DON was shown the count records for the fourth-floor carts A and B. DON confirmed that there were missing signatures on the record, which she agreed should have all been filled out. A review of the facility's record titled, Narcotic Count and key, dated May 1, 2006, was conducted. The record documented, The signature of the Licensed Nurses on the Shift Count of Narcotic Sheet confirms the accuracy and legal accountability for the drugs at the time of the count .A signature on a Narcotic Count Sheet means that you accept responsibility for the presence/absence of that dose/drug and are accepting, legal responsibility for the missing dose/drug.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125055	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hi'Olani Care Center at Kahala Nui	4389 Malia Street Honolulu, HI 96821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 43414 Based on record review and interview with staff member, the facility failed to ensure the attending physician reviewed an identified irregularity from the pharmacist's monthly medication review (MRR) for one of five residents sampled (Resident (R) 8). This failure had the potential for medication error and adverse consequences; the potential for R8 administered an as needed (PRN) medication without a frequency indicated in the physician's order. Findings include: Review of R8's MRR for the month of March, dated 03/16/24 documented Please add a frequency of administration to the prn Tylenol 325m [milligrams] tablet order. Follow-Through in the MRR was left blank. Review of R8's physician's order for Tylenol 325 mg tablet, GIVE 650 mg (2 TABS) by Mouth As Needed (NTE [not too exceed] 3 GMS [grams] APAP [acetaminophen]/DAY) For .BACK PAIN starting 09/22/23. The frequency was not included in the order. On 06/26/24 at 02:31 PM, an interview with Registered Nurse (RN) 5 was done. Concurrent record review of the MRR for March and physician's order, RN5 confirmed the MRR was not addressed, and the Tylenol order should include every four hours. Review of the facility's policy and procedure Monthly Drug Regimen Review with no effective date documented The Medical Director or the Associate Medical Director will review the report, make comments, and discuss any recommendations with the attending physicians, Director or Assistant Director of Nursing or the QAPI/CQI Committee on an as needed basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125055	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hi'Olani Care Center at Kahala Nui	4389 Malia Street Honolulu, HI 96821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on observations and interviews the facility failed to dispose of food items that have passed the use by date, failed to assure food items were stored in accordance with professional standards, failed to test temperatures of all food on the trayline and stored clean pots and pans on a rack that had rusty colored debris. This deficient practice puts all the residents and staff at risk for foodborne illnessess. Findings Include: 1) On [DATE] at 08:30 AM an initial tour of kitchen was done with dietician and Head Chef (HC). The following food items were found in the kitchen: expired chicken base found with a use by date of [DATE], pork with a prep date of ,d+[DATE] but no use by date, three containers of cooked pork in metal containers with use by date of [DATE]. The following items were found in the dry storage area opened with no open on and discard by date label: Almond Flour manufactures best by date of [DATE] with ,d+[DATE] written on front of package. Gelatine leaf gelatine open in box with the lid open, not sealed closed. Soup stock powder packet which was left open. Bottle of marsalla White truffle oil Curry block box was open and half of curry block was left in the open box and with an open wrapper. During the initial tour of the kitchen, interviewed HC and inquired if kitchen staff took temperatures of cooked food and HC stated the staff check the temperatures but do not log them. Facility was unable to provide any temperature logs of food cooked in their kitchen. One item (Dijon mustard) in the walk in refrigerator was found with a smudged unreadable opened label, unable to determine what the discard by date was. 2) On [DATE] at 11:20 AM, followed Dietary Aide (DA) 1 and Dietary Supervisor (DS) to deliver food to the trayline on the 5th floor. Food temperature checks were done for the following food items: broccoli, lasagna, soup and white rice. There were multiple containers of hot food on the trayline that were not tested at this time before the food was dispensed to the residents. Inquired how temperatures are taken and DS stated for 3 seconds. When surveyor did not say anything DS stated 10 seconds or when the temperature stops changing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125055	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hi'Olani Care Center at Kahala Nui	4389 Malia Street Honolulu, HI 96821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3) On [DATE] at 09:50 AM, revisited the kitchen and walked through with the Director of Dining Services (DDS) and facility dietician. During the walk through found a metal rack that had rusty colored debris which the clean pots and pans were stored on. Inquired of the DDS about the metal rack and he acknowledged the rack had rusty colored debris and stated he had this on order through his vendor. At this time requested copies of facility policies regarding labeling and food storage, temperatures of food cooked in the kitchen and trayline temperatures. On [DATE] dietician provided copies of facility policies requested. Review of facility policy titled Labeling Food Items, with an effective date [DATE], stated Procedure (Guidelines) 1. At the time foods are removed from hot or cold holding and placed in a container, Date with preparation date and the date is to be used or discarded. 2. At the time foods are removed from their original container and placed in another container, Date with preparation date and the date that it is to be used or discarded. 4. Items not included in the .labeling machine must be labeled by hand using appropriate labeling stickers as followed: i. Prepared foods must be labeled with the name of the item, date it was prepared and include a use by date set for 3 days. ii. Shelf stable items must be labeled with the name of the item, date it was opened and include a use by date set for 30 days. v. Raw meats must be labeled with the name of the item, date it was received, and include a use by date set for 5 days. Review of facility policy titled Kitchen Cooking and holding of hot food with an effective date of [DATE] stated IV. Procedure (Guidelines) B. The .[State] .defines properly cooked foods to reach and maintain the designated internal temperatures (beef minimum of ,d+[DATE] degrees Fahrenheit for rare, pork 155 degrees Fahrenheit, poultry 165 degrees Fahrenheit and fish 145 degrees Fahrenheit) for a minimum of 15 seconds measured with an instant read probe thermometer. C. Final cooking temperatures should be notated on log sheet notating the type of product, time the temperature was taken and the final cooking temperature. E. When the food is taken out of the holding cabinet and placed in the hot well. [sic] The temperature and time should then be noted on the designated log sheet. Review of facility policy titled Hot and Cold Foods (Trayline) with an effective date of [DATE] stated IV. Procedure (Guidelines) 1. The kitchen shall take the temperature of ALL foods using assigned thermometers. 2. The satellite kitchen staff are required to check the internal temperature of ALL hot foods to ensure they are greater than 135 degrees Fahrenheit for 15 seconds in the thickest part of the food. a. Foods between 41 degrees Fahrenheit - 135 degrees Fahrenheit for less than 2 hours must be reheated to 165 degrees Fahrenheit before being served. b. Foods between 41 degrees Fahrenheit - 135 degrees Fahrenheit for greater than 2 hours must be discarded immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125055	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hi'Olani Care Center at Kahala Nui	4389 Malia Street Honolulu, HI 96821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48351 Based on interviews and record review, the facility failed to maintain complete medical records for two of 16 sampled residents (Resident (R) 168 and R4). This deficient practice has the potential to affect all the residents in the facility. Findings Include: A review of R168's Electronic Health Record (EHR) was conducted on 06/24/24. During the review, R168's EHR only had weights documented on 05/22/24 at 89.8 pounds (lbs.), 05/28/24 at 89.8 lbs., 06/04/24 at 0 lbs. , and 06/11/24 at 80.0 lbs. A telephone interview was conducted on 06/26/24 at 11:10 AM with Director of Nursing (DON), regarding R168's documented significant weight loss. DON stated that with a significant weight loss, the assigned nurse would let the facility dietician know as soon as possible. DON agreed that based on the weight documented, R168's weight loss was significant, and the nurse should have notified the dietician. An second interview was conducted with DON on 06/26/24 at 01:00 PM. DON showed State Agency (SA) a piece of paper dated 06/12/24. The paper contained a handwritten note with R168's name and a reweigh of 86.9 lbs. DON was not able to tell SA which staff had written the note. DON stated that the staff had forgotten to document the weight in R168's EHR. DON also provided a printed EHR documentation dated 06/12/24. On the documentation it noted that it was edited on 06/26/24 at 12:27 PM by Registered Nurse (RN) 10. RN10 was not scheduled to work on 06/26/24. DON explained that RN10 came in to work to edit her 06/12/24 charting in the EHR. A follow up review of R168's EHR was conducted on 06/26/24 at 01:10 PM. The EHR now contained a documented weight of 86.9 lbs., dated 06/12/24. It also contained an edited note written by RN10, dated 06/12/24. The edited note contained additional documentation, Reweighed resident today=86.9 lbs. A follow up interview with DON was conducted on 06/27/24 at 10:39 AM. DON stated that resident weights and notes should be documented in the EHR prior to the end of shift. DON also confirmed that it should have been documented as a late entry. 37954 2) On 06/25/24 at 10:37 AM, record review of R4's hospice chart found there were missing documentation of recent progress notes, recertification and the last Medical Doctor (MD) visit summary. During this record review found the last progress note for R4 was dated 4/12/24. Also found the hospice nurse last signed the sign in sheet to visit the resident on 06/13/24. At this time inquired of the Nurse Educator/Infection Preventionist (NE/IP) if she knew where the documents were and she stated she did not know but would find out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125055	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hi'Olani Care Center at Kahala Nui	4389 Malia Street Honolulu, HI 96821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/24 at 11:04 AM, another record review was done of R4's hospice chart and found the updated progress notes faxed to facility on 6/25/24 in the afternoon. During this record review, found resident had a 60 day re-certification of terminal illness dated for 6/12/24 -8/10/24 for R4 who is a [AGE] year old female with hypertensive chronic kidney disease with multiple comorbidities. This recertification form was faxed to the facility on [DATE] at 14:27 (02:27 PM). MD recert visit summary was dated 5/13/24 at 12:14 PM and faxed to facility on 6/25/24 at 15:14 (03:14 PM). One hospice nursing progress note was faxed on 6/25/24 at 15:14 (03:14 PM) and was dated for 05/30/24 at 10:27 AM by the hospice nurse. Two more hospice nursing progress notes were faxed on 6/25/24 at 15:43 (03:43 PM). The notes were dated on 6/6/24 at 6:09 PM and 6/13/24 at 05:34 PM and both signed by the hospice nurse. On 06/27/24 at 09:49 AM, interviewed Assistant Director of Nursing (ADON) and Director of Nursing (DON) regarding R4's missing hospice documents. Inquired how facility communicates with hospice and what is the expectation of hospice to provide progress notes. DON stated hospice nurses communicate with the assigned nurse after they meet with the residents and hospice staff fax or bring the progress notes in person. Restated progress notes, hospice recertification form and MD summary were added to R4's hospice chart on 06/26/24 after surveyor had requested items. At this time, requested and received facility policy titled Coordination of Care - Hospice Services. Review of facility policy titled Coordination of Care - Hospice Services with effective date of 03/30/16. Review of the policy found the following: The designated .[facility] .interdisciplinary team member are responsible for: 7. Ensuring that the documentation in the Resident's medical records is complete, up to date and filed in the appropriate place in the Resident's binder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125055	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hi'Olani Care Center at Kahala Nui	4389 Malia Street Honolulu, HI 96821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 43414 Based on observation, interview and record review the facility failed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of communicable diseases and infections for one of four residents sampled for infection control (Resident (R) 118). R118's humidifier bottle was not properly secured to the oxygen concentrator. This failure could place the resident at risk for infection. Findings include: R118 was admitted to the facility on [DATE] with Hospice and diagnoses, not limited to, bronchiectasis (a chronic lunch condition where the wall of your airways widen and are thickened from inflammation and infection) and chronic obstructive pulmonary disease (COPD) (a chronic inflammatory lunch disease that causes obstructed airflow from the lungs.) Review of R118's Electronic Health Record (EHR) found R118 uses an oxygen contractor at 1.5 - 2 liters per minute for COPD and bronchiectasis. On 06/24/24 at 09:33 AM, during an observation of R118's room, observed R118 on oxygen, oxygen contractor running, and the humidifier bottle hanging from the concentrator touching the ground. The metal clamps that secure the humidifier bottle to the contractor was not found. R118 reported she did not notice it on the ground and received a new humidifier bottle about a week ago and stated it must not fit on the concentrator. R118 was not able to recall how long the humidifier has been on the ground. On 06/25/24 at 08:50 AM observed R118's humidifier bottle taped to the oxygen concentrator. On 06/27/24 at 11:38 AM interview with Nurse Educator/Infection Preventionist (NE/IP) was done. Showed NE/IP a picture of the oxygen concentrator in R118's room as observed on 06/24/24 at 09:33 AM and inquired if there was something wrong with what was pictured, NE/IP reported the water humidifier should not be on the ground. NE/IP reported this could be a source of contamination for infection control.