| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125059 | A. Building<br>B. Wing | 09/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Palolo Chinese Home | 2459 10th Avenue<br>Honolulu, HI 96816 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Based on interviews and record review, the facility failed to identify and intervene for an acute change in a resident's condition related to a stroke for one (Resident (R) 4) of three residents sampled, resulting in the family telling the facility to transport the resident to the hospital.Care plan did not address the resident's stroke or include interventions for the prevention of aspirationStaff did not identify R4's occasional moist cough when eating as an early symptom of aspirationStaff did not communicate to the physician that the resident's cough had occurred while eating Staff did not follow the physician's orders for treatment of symptoms of R4's coughConflicting information in the documentation, which did not relay the resident's distress when positioned on his backAs a result of these deficient practices, the resident was admitted to the hospital in respiratory distress due to aspiration and is currently receiving hospice services (less than 6 months life expectancy). Findings Include: On 09/04/25 at 12:07 PM, conducted a telephone interview with R4's Family Member (FM). During the telephone interview FM reported visiting R4 from approximately 03:30 PM to 06:00 PM on 08/13/25. During that time, R4 was breathing on his own, not coughing, and no respiratory distress symptoms (i.e. supplemental oxygen, coughing up mucous, or audible wheezing). At 10:18 PM, FM received a call from the facility informing her that R4's oxygen (O2) levels had decreased to 78%, which was a significant change from his earlier presentation. Facility staff discussed life saving measures and FM's care preferences. FM informed the facility it was okay to send the resident to the hospital and wanted to be updated on the resident's condition. FM stated she did not hear anything more from the facility and was under the impression R4 was okay. However, when FM visited R4 at approximately 07:30 AM the next morning, FM stated R4's state of condition had dramatically declined overnight. R4 appeared run down. R4 was coughing, on oxygen, and it looked as if R4 had not slept all night. FM reported hearing audible wheezing from the resident. FM sought out facility staff and requested for R4 be transported to the hospital immediately. FM stated he/she was upset and disappointed the facility did not do more for R4 and had not sent the resident to the hospital or been informed of R4's condition change. According to FM, any reasonable person could hear and see that R4 was in distress. On 09/04/25 at 12:08 PM, conducted a review of R4's Electronic Health Record (EHR). R4 was admitted to the facility on the afternoon of 08/13/25 with diagnosis of, but not limited to, acute multifocal strokes, symptomatic bradycardia (low heart rate), atrial fibrillation, hypertension, hearing loss, and Dementia. R4 did not have a cough and was breathing normally on room air with oxygen saturations at 94% and was at the facility for physical and occupational therapy rehabilitation. R4 was transferred to the hospital and subsequently discharged from the facility in the morning of 08/14/25. Reviewed R4's care plan. The care plan addressed altered fluid balance, falls, and safety, but did not address the resident's recent stroke (08/02/25) or include interventions as a standard of practice for stroke residents. For example, ensuring the head of the resident's bed (HOB) be elevated for aspiration (the inhalation of substances, i.e. food, thickened saliva, or drinks, into the lungs) prevention during and after meals and/or medications. For residents who have experienced a stroke, it is common practice to ensure the HOB is elevated at all times and the resident does not lay flat on the back to prevent aspiration. Review of the progress notes documented on:Written on 08/13/25 at 10:02 PM, .occasional moist cough noted when eating .Resident noted with increased moist cough and audible congestion around 2100 (09:00 PM). Suctioning performed producing large amounts of white sputum. O2 sat (saturation) to 78% on RA (room air). On 08/13/25 at 11:28 PM, documented new physician orders for 1) Duoneb (breathing treatment) inhaled every 4 hours as needed for cough/shortness of breath/wheeze 2) Robitussin 10 milliliters (ml) every 4 hours as needed for cough. A late entry progress note was written on 08/15/25 at 02:13 AM, for 08/14/25 at 05:58 AM, which documented .No noted congestion or cough .Endorsed to CNAs (certified nurse aide) and will endorse to morning shift that HOB needs to stay up . This progress note was written after the resident was discharged to the hospital. (Cross reference to F842: Resident-Identifiable Information)Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented staff did not administer Duoneb or Robitussin as ordered by the physician to alleviate R4's cough/wheezing. Conducted a concurrent interview and record review with Registered Nurse (RN)3 on 09/04/25 at 01:35 PM. RN3 stated he was given report from the night shift nurse (RN12) and was informed that R4's oxygen levels desaturated to 78% SpO2 on their shift. RN12 also informed RN3 of R4 coughing throughout the night and white sputum upon suctioning (which was later included into R4's progress notes as a late entry, after the resident had already been discharged to the hospital). Inquired with RN3 as to what prompted him to send |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on interviews and record review, the facility failed to maintain accurate documentation in a medical record for one (Resident (R) 4) of three residents sampled. Late entries affected the care the resident was provided and did not reflect an accurate presentation of the resident. Finding Include: (Cross Reference to F684- Quality of Care)1) Review of R4's Electronic Health Record (EHR) documented Registered Nurse (RN) 12 wrote a late entry progress note on 08/15/25 at 02:13 AM for 08/14/25 at 05:58 AM, after the resident was discharged to the hospital. The progress note written documented, endorsed to CNAs (Certified Nurse Aide) and will endorse to morning shift that R4's Head of Bed (HOB) needs to stay elevated. However, this progress note was entered into the resident's Electronic Health Record (EHR) late. As a result of a late entry this information the resident's record was incomplete. This incident could be pertinent to other facility disciplines in assisting the resident to reach his/her highest attainable physical well-being. As a result of the late entry, instructions to elevate R4's head of bed was not communicated to staff. 2) During an interview with RN13 on 09/04/25 at 02:56 PM, discovered a late progress note RN13 wrote on 09/04/25 at 02:46 PM (prior to the interview) for 08/13/25 at 10:40 PM. The progress note documented that RN13 notified Physician (P) 1 that R4's coughing and wheezing had decreased. However, during a telephone interview with P1 on 09/05/25 at 11:41 AM, P1 confirmed he did not receive a second phone call from RN13 reporting R4's decreased coughing and wheezing. |