STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kauai Care Center	9611 Waena Road Waimea, HI 96796

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, document and record review, the facility failed to provide and document sufficient preparation to ensure that one Resident (R)1 of a sample size of three had the resources and support to meet his needs when discharged to the community. R1 had a Provider order for 24 hour supervision, but was discharged with a Private Hire (PH) two hours a day. There was lack of evidence that R1 was informed of the need for more supervision, or that the risks of refusing ordered services were discussed and understood. The post-discharge plan did not address resident limitations in ability to care for himself, which increased the risk of complications, and readmission to the hospital. This deficient practice could affect all Resident's being discharged to the community. Findings Include:1) On 10/15/25, the Office of Health Care Assurance received a concern that R1: 1) lived alone and did not have a caregiver, 2) due to physical or mental impairment, or both, could not perform essential tasks to care for himself, 3) had difficulty standing and frequent falls, 4) did not remember how to use his alert alarm, 5) had spoiled food in the apartment, and 6) had food and feces on the floor. R1 was an [AGE] year-old male admitted to the facility on [DATE] for medical management and rehabilitation after a stroke. His medical history included but not limited to encephalopathy (conditions that cause brain dysfunction, leading to symptoms such as confusion, and memory loss), muscle weakness, abnormalities of gait and mobility, Type 2 Diabetes Mellitus on insulin, non-pressure chronic ulcers of both heels, and hypertension. While at the facility, R1 had incontinence of bladder/bowel and wore disposable briefs. Prior to the stroke, he lived alone, was independent, had a Care Coordinator (CC) in the community assigned by his insurance company. He had been receiving meals on wheels, transportation and had a life alert system to call for help in an emergency. R1 had a neighbor who assisted with groceries, and a friend (F)1 who helped clean the house. He did not have a Power of Attorney. 2) Reviewed the Interdisciplinary Care Conference-V7 record for R1 dated 09/18/25, which included: D. Nursing Summary .Discharge home with family. G. Social Services Summary. A&OX2 (oriented to self and place), usually able to make needs know and understand others.He live alone.has community services and health coordinator .Return home with established services ., HH: PT/OT/NRSG (Home Health: Physical Therapy//Occupational Therapy/Nursing). I. Therapy and Restorative Care Summary (documented by MDS Coordinator) .Discharge home with family L. Discharge Planning .Lives alone.Private hire, .health coordinator (CC) will coord. This section documented that R1 had family, or a support network to provide assistance post discharge, and that that the primary caregiver was Wife. The discharge plan intervention checked was Evaluate and discuss with resident/family/caregiver the prognosis for independent or assisted living. Identify, discuss and address limitations, risks, benefits and needs for maximum independence. This Care Conference was inconsistent and inaccurate. R1 did not have a family or wife, and the PH was arranged by the facility. There was lack of evidence that the facility had a discussion of the prognosis of independent living with minimal supervision, R1's limitations or that he fully understood the risks. In addition, there was no evidence that the provider was aware of the final discharge arrangements of minimal supervision. Record review revealed R1 made progress in PT/OT and on 09/23/25, his (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	insurance issued him a notice of non-coverage with a discharge date of 09/26/25. R1 wanted to go home and did not appeal the discharge.Record review of Discharge Orders dated 09/23/25 revealed the level of supervision checked off was 24 Hour Care. The Home Health Services/Outpatient referrals included:1) Home Health PT), 2) HHOT, 3) HHST (Speech Therapy), and 4) HH/NSG (Nursing). A handwritten entry medication management was added. The document was signed by the Nurse Practitioner (NP)1 and dated 09/23/25.Reviewed the discharge MDS (Medical Data Set) assessment dated [DATE], which included the following: Section GG-Functional Abilities indicated R1 required partial/moderate assistance for toileting/hygiene, shower/bathe self, putting on footwear and personal hygiene. In addition, R1 was assessed as needing supervision or touching assistance for roll left to right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to chair transfer, toilet transfer, and walking. Section H- Bladder and Bowel documented R1 to be always continent of bladder and bowel. Reviewed documentation of R1's urinary continence/incontinence for the time period 09/19/25 to 09/26/25, which revealed he was incontinent of urine 21 times and incontinent of bowel nine times during that time.Reviewed the Physical Therapy Treatment Encounter Note dated 09/24/25. The plan was . Pt (patient/R1) to be seen for his final PT tomorrow. Pt is not safe to be home alone and PT recommending increased assist at home. Reviewed PT Discharge summary dated [DATE] by PT1, which included Patient is now ambulating and performing his mobility at a CGA/SBA (contact guard assist (provides occasional physical support to ensure safety))/stand by assist (present for safety but does not provide direct support) level. Reviewed Occupational Therapy Treatment Encounter Note(s) dated 09/24/25. The note included .home with 24/7 care and HHOT/PT on 9/26/25.Reviewed OT Discharge summary dated [DATE] by OT1, which included . Pt has made gains, however continues to need assistance and is recommended to have a caregiver at least 20 hours a week, per modified Barthel index score . R1's modified Barthel ADL score (level of assistance required for activities of daily living) score was 61 (Moderate dependence, including that the resident requires some assistance with most ADLs). Reviewed R1's nursing progress notes, which included: 09/23/2025 12:53 PM: Alert note: .Resident with persistent diarrhea and stomach upset. New orders received to collect stool for culture and O&P (test to detect presence of intestinal parasites) and add probiotic 1 capsule BID. 09/26/25 11:00 AM: Resident discharged home discharge instructions/summary given to caregiver. Review of R1's lab results revealed no results for the stool culture. A report from the laboratory was sent to the facility which notified them the test could not be done. The report said . Stool sample recvd (received) in sterile container not in stool media. Already passed stability to add to stool media. Spoke to .at Kauai Care Center, .resident no longer at facility, so no need to recollect. There was no documentation the provider, PMD, or Resident was notified that the test was not completed.3) On 02/19/26 at approximately 01:00 PM, during an interview with the Social Service Assistant (SS). She confirmed R1 did not have family or a full-time care giver. She said he had some services prior to admission and spoke with his community Care Coordinator (CC) to inform her R1 he received the notice of Medicare non-coverage, did not appeal the discharge and wanted to go home. The CC told the SS meals on wheels would resume on 09/29/25 and told her R1 had limited money, and that she would work on staffing for the ordered services, but that there was a staffing shortage. When asked SS who the caregiver was referenced in the nursing note at the time of discharge, she stated it was a Private Hire (PH) she (SS) was able to arrange. She went on to say she was concerned and knew he needed to be looked at every day and there would be a lag until other services could be arranged. SS said she did not know the qualifications of the PH, but R1 agreed to hire her two hours a day. SS knew R1 needed an insulin shot every day and said it would be nursing's responsibility to ensure someone was capable and competent do the injections. When asked if she or anyone else had any discussion with R1 about a Long-term care (LTC) facility or 24-hour supervision, she said she did not, but knew someone else did. SS said an 1147 (Hawaii form to determine level of care and at-risk evaluation to ensure appropriate level of supervision provided), would be done by nursing, or after he left the facility.On 02/20/26 at 12:25 PM, SS provided a Case Management Note (continued on next page)

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