STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125064	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ching Villas	2230 Liliha Street Honolulu, HI 96817

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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 - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to notify the physician that two of three residents (R)1, and R2 sampled had a change of condition that required administration of oxygen. The deficient practice of not notifying the physician of a change of condition could affect any resident, and places them at risk for not getting the appropriate treatment that may result in a negative outcome. Findings include:R1's electronic medical record (EMR) reviewed. R1 was an [AGE] year-old male admitted to the facility on [DATE] for rehabilitation after hospitalization for an acute stroke. As a result of his stroke, he had dysphagia (difficulty swallowing), expressive aphasia (communication disorder due to stroke that affects person's ability to speak, write, and understand). R1 had mild cognitive impairment and was alert and oriented (A&O) x1 (aware who he was, but not aware of location, time, or situation), was dependent on staff for all activities of daily living and required 1:1 feeding assistance. R1 had an order for Difficulty breathing: Oxygen (O2) 1-4 LPM (liters per minute) via nasal cannula for SOB (shortness of breath) or SpO2 <90% (peripheral capillary oxygen saturation measuring percentage of oxygen in the blood. (Normal 95%-100%)); Frequency as needed (PRN). Review of R1's nursing notes revealed R1 did not have any difficulty breathing or signs/symptoms (i.e. wheezing, low oxygen saturation level) that would indicate the need for oxygen, until 09/15/25. On 09/15/25 nursing note charted at 09:53 PM read: .Guest had SOB around 15:30 (03:30 PM), O2 (Sp02) 87-89 (%), breathing even and unlabored, lung sounds clear, applied Oxygen 2L, O2 92-94%, did routine checks on guest, O2 was 97-98%, started to wean guest off oxygen by going to 1L, O2 94-95%, breathing even and unlabored. Endorsed to oncoming noc (night) shift nurse. There was no documentation that R1's Provider was notified of this change of condition that required prn oxygen administration. In addition, there was no documentation how long R1 required the oxygen. On 10/09/25 at 01:00 PM, during an interview with the Director of Nursing (DON), after review of R1's records, he said he could not determine when R1 was taken off the oxygen on 09/16/2025, and that there was no documentation the physician was notified. The DON confirmed this met the criteria for a condition change, and the provider should have been notified. Interview with Registered Nurse (RN) 1 on 10/09/25 at 10:30 AM revealed that the facility uses a binder (communication book) to write notes in, to inform the Providers (Physicians and Advance Practice Registered Nurse (APRN)) of non-emergent concerns and needs for the residents, i.e. medical appointments, increase and decrease in medication dosage and things that can be addressed the next day. RN1 said this decreased the number of calls made to physicians/APRNS. It is utilized by the nurses, physicians, APRNs, Speech Therapist (ST), Occupational Therapist (OT), and Physical Therapist (PT). The RNs are to check this communication book at the beginning of their shift and if they need clarification on what has been noted, they will call the respective disciplines. RN1 further stated that physicians will look at the book on a Monday, Wednesday, Friday, the days they are scheduled to see their assigned residents and document their responses. The APRNs are scheduled on the Tuesday, Thursday schedule. RN1 noted that there are no physicians/APRNs that come on the weekends, so if there are any issues that come up and cannot wait till the following Monday, they would page the on-call physician. Record review of the facility's communication book on 10/09/25 at 01:30 PM noted that on 09/27/25 (Saturday, time not specified) R2 complained of shortness of breath (SOB). RN 2 assessed R2's lungs and noted them to be clear to auscultation bilaterally and oxygen saturation (SPO2) at 96%. RN2 elevated head of bed and administered oxygen at one liter (L) with positive effect and SPO2 increased to 98%. Physician's response in the MD's response column of the communication book noted ok (time and reviewed date not indicated).Record review of R2's EMR on 10/09/25 at 01:45 PM revealed the nursing progress notes had no documentation of R2's complaints of having shortness of breath on 09/27/25, and no documentation of notification to the on-call physician. There was no previous documentation noted of R2's complaints of having any SOB. A Physician's order was entered on 09/21/25 for Oxygen 1-4 L via nasal cannula for SOB or SPO2<90%, with special instructions to notify MD if 02 is applied or increased.Interview with the DON on 10/09/25 at 02:00 PM confirmed the order to notify MD and said for resident's who required 02 for the first time, a call to the physician should have been made, including at night, when the O2 was needed and administered, as it is considered a change in condition. The facility's Change in a Resident's Condition or Status policy, with a revised date of 05/19/23 was reviewed on 10/09/25. It notes The facility shall notify resident, his or her Attending Physician of changes in the resident's medical/mental condition and/or status. 1. The nurse will

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the nursing staff provided the standard of quality care to one of three Residents (R)1 sampled. 1.) R1 had a peripheral intravenous access (PIV) in his right arm for three days, with no order. 2) Staff used R1's hospital weight as his baseline weight upon admission, and 3) Licensed Staff (LS)4 did not document a neurological assessment and monitoring as required, to ensure there was no change of condition. The deficient practice placed R1 at an increased risk of infection at the catheter site; an increased the risk of his nutritional needs not being met; and an increased risk of acquiring an unidentified medical condition that may result in a negative outcome. Findings include:R1's electronic medical record (EMR) reviewed. R1 was an [AGE] year-old male admitted to the facility on [DATE] for Physical and Occupational Therapy after hospitalization for a stroke. As a result of his stroke, he had dysphagia (difficulty swallowing), and expressive aphasia (communication disorder that affects the ability to speak, write, and understand). R1 had mild cognitive impairment and was alert and oriented (A&O) x1 (aware who he was, but not aware of location, time, or situation). He was dependent on staff for all activities of daily living, required 1:1 feeding assistance and was at risk for malnutrition and dehydration. Review of R1's nursing progress notes revealed an entry recorded as Late Entry on 09/06/2025 at 08:02 AM. Guest was newly admitted on [DATE] .Received him asleep in bed with even and unlabored respirations. Guest made a moaning sound when I tried to wake him, but he never opened his eyes. Unable to do final Glasgow Coma Scale or CVA (stroke) Neurocheck (neurological assessment) under Observations (location in record details). Note left in MD binder (used to communicate non urgent information to providers).Frequent visual checks and rounding for added safety. (No time documented in the note). The next progress note entry was 05:22 PM that day. No documentation found about R1's condition on rounding, or evidence that the licensed staff attempted to reassess R1's neurological status during the shift after he was unable to be woken. During an interview with the Director of Nursing (DON) on 09/17/25 at 01:15 PM, he said the facility had developed a stroke program, and all staff were required to attend education on the care of Residents post stroke. The DON agreed the neuro assessment should have been completed and documented. Reviewed the content of the stroke education provided by the DON, which included the three components of the Glasgow Coma Scale; motor, verbal and eye opening, and directed staff to Don't be afraid to stimulate these patients, describe what you see .Be vigilant to changes, Recognize subtle clues . 2) On 09/03/25 at 11:18 AM, RN6 completed the admission assessment (admission Observation), which included in the Skin Status section that R1 had a RUA IV (catheter for peripheral intravenous (PIV)) for the administration of fluids in the right upper arm). On 09/05/25 at 07:10 AM, RN7 documented .the aide found that guest had pulled out his R PIV. Guest bleeding from his arm. Cleansed w/NS (with normal saline) and applied gauze . Reviewed R1's orders, which revealed there was no order for the PIV.3) Reviewed R1's admission assessment, where Facility Staff (FS)4 documented R1's weight on 09/02/25 at 09:00 PM as 195.8 pounds (lbs.). Reviewed Vitals Report, that documented on 09/03/2025 at 11:09 PM, his weight was 174.8 lbs. (21 lb. loss), and on 09/04/25 at 09:38 PM, the weight was 156.8 lbs. (39 lb. total weight loss since admission). There was no repeat weight to confirm accuracy and there was no documentation either day that Nursing Staff or the Provider was notified. Reviewed the Observation Detail List Report, Nutrition admission Assessment recorded on 09/08/25 at 02:38 PM. The report included Questionable wts. (weights) of 156.8# and 195# on 9/4/25 and 9/2/25 not used d/t (due to) wt. error. Son made aware of wt. discrepancy; son states likely error d/t guest's UBW (usual body weight) 180-185#. Daily weights requested for closer monitoring.On 10/09/25 at approximately 01:00 PM, interviewed Facility Staff (FS) 4 in the conference room. At that time reviewed R1's medical records and FS4 confirmed he/she documented the admission weight of 195.8 lbs. FS4 said he/she had been told by the nurse on duty to take the weight off the hospital records and record as the admission weight. On 10/09/2025 at approximately 01:15 PM, interviewed the DON, who said the facility policy and expectation was to take the admission weight on the facility scale. He also said if there was a significant loss like this, the staff should repeat the weight to ensure accuracy and report the loss to the nursing staff.

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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. Based on an interview and record review, the facility failed to identify and report a medication error to the Administrator or Director of Nursing (DON) for review and appropriate action as required by facility policy. Resident (R) 1 was ordered Lisinopril (to treat high blood pressure) 2.5 mg (milligrams) orally and hold the medication if the resident's Systolic Blood Pressure (SBP) was less than 120 millimeters (mm) of mercury (Hg). Although R1's SBP was documented as 113 mm Hg, the Lisinopril was administered, when it should have been held. Findings Include: R1's Electronic Medical Record (EMR) reviewed on 10/09/25. The physician orders documented an order for Lisinopril 2.5 mg, to be given once an evening, hold for systolic blood pressure (SBP) less than 120 (started on 09/03/25, ended 09/16/25). R1's September 2025 Medication Administration Record (MAR) reviewed. On 09/12/25 R1's SBP was documented to be 113, lower than the required parameter for administering the medication. The medication order was not followed, and the resident was administered Lisinopril 2.5 mg. On 10/09/25 at 11:15 AM, conducted an interview and concurrent review of R1's MAR for 09/12/25 with the DON. He confirmed R1's SBP was 113 and the Lisinopril should have been held. Also, the DON confirmed the facility did not identify this medication error prior to this interview and no report was done.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, document review and interviews, the facility failed to ensure the medical records of three Resident's (R)1, R2 and R3 were complete and accurate. 1) R1 and R2's records did not include complete, accurate documentation of oxygen administration. 2) R1's records included a nursing progress note of an assessment on a different resident and in error, entered into the wrong record. 3) R3's discharge notice included inaccurate information regarding her current condition.Findings include:R1's electronic medical record reviewed (EMR). R1 was an [AGE] year-old male admitted to the facility on [DATE] for rehabilitation after hospitalization for an acute stroke. As a result of his stroke, he had dysphagia (difficulty swallowing), expressive aphasia (communication disorder due to stroke that affects person's ability to speak, write, and understand). R1 had mild cognitive impairment and was A&O1x (aware who he was, but not aware of location, time, or situation), was dependent on staff for all activities of daily living and required 1:1 feeding assistance. Review of R1's nursing progress notes revealed the following entry on 09/13/25 at 10:01 PM: Guest was admitted for PT/OT (physical/occupational therapy), primary diagnosis (Dx): Acute cholecystitis (inflammation of the gallbladder), abdominal pain RUQ (right upper quadrant) and RLQ (right lower quadrant), acute cystitis (inflammation of bladder) without hematuria, respiratory Acidosis pacemaker . Guest is alert and oriented x4.she is able to eat independently . was entered into R1's electronic medical record (EMR) in error, which was not identified prior to the survey. R1 had an order for Difficulty breathing: Oxygen (O2) 1-4 LPM (liters per minute) via nasal cannula for SOB (shortness of breath) or SpO2 <90% (peripheral capillary oxygen saturation measuring percentage of oxygen in the blood. (Normal 95%-100%)); Frequency as needed (PRN). Review of R1's nursing notes revealed R1 did not have any difficulty breathing or signs/symptoms (i.e. wheezing, low oxygen saturation level) that would indicate the need for oxygen, until 09/15/25. Further review revealed the facility utilized three separate methods to document the administration of oxygen for R1, (nursing notes, vitals Report, and respiratory Administration Record.) Review of these documents revealed they are not systematically organized and did not provide accurate documentation of oxygen use. The notes included following: Nursing note findings: On 09/15/25 nursing note charted at 09:53 PM read: .Guest had SOB around 15:30 (03:30 PM), O2 (Sp02) 87-89 (%), breathing even and unlabored, lung sounds clear, applied Oxygen 2L, O2 92-94%, did routine checks on guest, O2 was 97-98%, started to wean guest off oxygen by going to 1L, O2 94-95%, breathing even and unlabored. Endorsed to oncoming noc (night) shift nurse. 09/16/25, there was no day shift nursing note. 09/17/25 at 08:01 AM: Late entry: Received guest asleep on 1LPM NC (nasal cannula). O2 was 96% on 1LPM. 09/17/25 at 11:09 PM: Respirations unlabored, SPO2 94-96% on RA (room air) with fluctuations down to 91% while asleep. Lungs CTA (clear to Auscultation). These nursing notes are incomplete because 1) there was no day shift assessment 09/16/25, 2) no lung assessment 09/17/25 day shift, and 3) 09/17/25 at 11:09 PM, it was documented R1 was on RA, but there is no documentation when he was taken off the prn oxygen. Respiratory Administration Record (RAR) reviewed from admission to 09/18/25. This record is for documentation of the PRN administration of oxygen. Page one of the form had three areas per day to document each PRN administration, and page two provides an area to document the date, time and reason/comments for each separate use. Review of the RAR revealed one entry on page 1 for prn administration on 09/16/2025, charted time 22:47 (10:47 PM). Page 2 included the following two entries: PRN 1 Reason: SOB (shortness of breath) around 15:30 (03:30 PM), administered O2 (oxygen) @ 15:40 (3:40 PM) for 2LPM PRN 1 Result-Follow-up: Effective. Comment: guest O2 95-97% on 2L wean to 1L O2 94-95%. This document does not coincide with nurse's notes, which indicated the first PRN O2 was administered on 09/15/25. The Vitals Report should include O2 Saturation % and note if oxygen is being administered. Reviewed the report from 09/15/2025 to 09/18/2025, which included the following entries: 09/15/2025 at 16:51-17:20 (04:51 PM-05:20 PM): Vitals taken, but did not include O2 saturation, or if R1 was on oxygen. Per nurse notes, placed on O2 at approximately 03:30 PM 09/16/2025 00:55 AM: O2 Saturation 93% Oxygen Use: No. 09/16/2025 10:32 AM: O2 Saturation 97% Oxygen Use: No. 09/16/2025 03:38 PM: O2 Saturation 97% Oxygen Use: No. 09/16/2025 10:43 PM: O2 Saturation 87% Oxygen Use: No. 09/16/2025 10:52 PM: O2 Saturation 91% Oxygen Use: Yes - Liter flow 1 09/17/2025 07:01 AM: O2 Saturation 96% Oxygen Use: Yes - Liter flow 1 09/17/2025 02:40 PM: O2 Saturation 94% Oxygen Use: No. The Vitals Report did not include the prn O2 noted in progress note 09/15/25 a 03:30 PM. It also indicated

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to ensure safe handling and disposal of a soiled bed pad/brief for one Resident (R)1. R1 was transferred to the hospital from the facility on 09/18/25. The resident's belongings were collected from R1's room, bagged, and placed at the nursing station until it was picked up by R1's Family Member (FM)3 on 09/22/25. FM3 discovered a soiled bed pad/brief in a bag marked as the resident's belongings. Findings Include: On 09/25/25 at 07:50 PM, the State Agency (SA) received a complaint via email that a soiled (with urine and feces) bed pad/ brief was found in a bag given to them as part of the resident's belongings. The bag was labeled with R1's name and room number. Pictures of all the resident's belongings bags (five bags; one gift bag with a balloon, two blue personal belongings bags, and two clear bags). In a picture (P1), in one of two Clear Bags (CB)1, any reasonable person could identify blue material (bed pad/brief), inside the bag just by looking at it. A second picture (P2) documented the inside of CB1, which contained a visibly soiled item with brown material (feces/urine) at the bottom of the bag. On 10/08/25 at 11:42 AM conducted a concurrent interview and observation of R1's assigned room with Certified Nurse Aide (CNA)45 and CNA3. Both staff confirmed they packed all of the resident's belonging in bags and placed it in the nursing station for the resident's family.On 10/08/25 at 01:40 PM, conducted an interview and review of the picture of the bags with CNA45. Showed CNA45 P1, then inquired if staff recognized the bags as R1's belongings. CNA45 confirmed and recognized all five bags mentioned above as R1's belongings. CNA45 attested to packing the two blues belonging bags but confirmed he/she did not pack any clear bags. On 10/08/25 at 01:43 PM, conducted an interview and review of the picture of the bags with CNA3. CNA3 reviewed P1 and confirmed all five bags in the pictures were identified as R1's belongings. Inquired with CNA3 about the clear bag (with the bed pads visible at the bottom). CNA3 confirmed bed pads were visible at the bottom and identified R1's boots at the top of CB1. CNA3 could not recall which bags he/she packed but insisted that he/she would not have knowingly put the resident's belongings in with a soiled bed pad/brief. On 10/08/25 at 02:03 PM, conducted an interview and review of facility video surveillance with the Administrator and two other surveyors present. The Administrator presented video surveillance of the Unit Clerk (UC) handing off R1's belonging to FM3. In the video, FM3 and UC are seen looking through two of the blue belongings bag and did not look through CB1 identified in P1, which contained the soiled bed pad/brief.Reviewed CB1, P1, and P2 with the Administrator. Administrator confirmed bed pads/ briefs, and the protection boots are visible through CB1, and that same bag was in the video as part of R1's belongings sent home with FM3. Also, the Administrator confirmed the bed pad/briefs were soiled. After reviewing the video surveillance and pictures, the Administrator confirmed the bag which contained soiled bed pads/briefs was given to R1's FM3 as part of the resident's belongings.