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	01/16/2026

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

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** Based on observations, interviews, and record review, the facility failed to develop a plan of care to include oxygen (O2) therapy for one of two Resident's (R) 178 sampled for O2 therapy; and failed to implement the care plan for bilateral heel protectors for one of one resident, R173 sampled for having bilateral lower extremity (BLE) edema and cellulitis. This deficient practice puts the residents at risk for not achieving their treatment goals.Findings Include:On 01/13/26 at 10:40 AM, observed R178 with 02 at one liter (L) via nasal cannula (NC). R178 said the 02 is helping him with his breathing but feels he would be ok without it. R178 was admitted on [DATE] with a primary diagnosis of postprocedural complications and disorders of the digestive system and has a history of diaphragmatic hernia. On 01/13/26 at 1:30 PM, observed R178 without 02 and no signs or symptoms of respiratory distress. On 01/14/26 at 09:00 AM, observed R178 with 02 at 1L via NC, but denied having any breathing issues.On 01/14/2026 at 10:00 AM, record review of R178's Electronic Health Record (EHR) noted a physician's order for continuous O2 supplementation 1-4 liters per minute (LPM) via NC for shortness of breath (SOB) or Sp02 (oxygen concentration) <90%, dated 01/12/26. On 01/14/26 noted orders to wean O2 as tolerated every shift. Review of R173's care plan did not include any problems, goals, and interventions for O2 therapy.On 01/16/26 at 08:30 AM, interview with Assistant Director of Nursing (ADON) confirmed that there was no O2 therapy in R178's care plan and that it should have been included. The ADON also acknowledged that the care plan is important as it directs the care provided to the residents. Review of the facility's Oxygen Administration policy, dated 10/01/2024, on 01/16/26, in the Procedures section, it notes, 16. The resident's care plan will identify the interventions of oxygen therapy, based upon the resident's assessment and orders.2) 01/14/2026 9:48 AM, observed R173 in bed with BLE edema, redness, and dry scaly skin. BLE exposed with no socks or heel protectors applied. R173 stated her skin is very sensitive and complained of pain at an 8 out of 10 on the pain scale. She said they have been giving her pain meds with relief and applying cream every day for the dryness. At 11:00 AM, observed R173 in bed, with BLE still exposed and no heel protectors applied.At 2:50 PM, observed R173 in bed, with BLE still exposed and no heel protectors applied.At 3:00 PM, record review of R173's EHR noted physician's orders to have bilateral heel protectors in place. Review of the care plan noted to ensure heels are offloaded by floating heels while in bed.AT 2:57 PM, interview with Registered Nurse (RN) 1 confirmed that the heel protectors should have been reapplied to R173's feet after her physical therapy (PT) and shower. RN1 acknowledged that this is to protect resident from further skin breakdown. On 01/16/26 at 01:00 PM, review of the facility's Comprehensive Care Plan policy, dated 10/01/24, in the Policy Statement it notes, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident/guest.that includes measurable objectives and timeframes to meet a resident/guest's medical, nursing,.that are identified in the resident/guest's comprehensive assessment.

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 0689 Level of Harm - Minimal harm or potential for 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 observation, interview and record review, the facility failed to ensure two of three residents sampled for accidents were free from accidents. Resident (R) 185 had a fall and R58 received a skin tear when transferred with a mechanical device to a wheelchair. The deficient practice placed the residents at risk for injury. Findings include: During an observation of R58 in her room and interview with family members (FM) 1 and FM2 who were at the bedside on 01/14/2026 at 11:55 AM assisting R58 to eat lunch. FM1 stated that the staff need to be more careful when they use the Hoyer lift to transfer R58 because her skin tears easily. She has had problems with skin tears, and it happens when she is transferred. Observed R58 with the Geri sleeves on both of her arms. Reviewed the Resident Grievance/ Complaint Form dated 7/22/25. The FM stated that one Certified Nurse Aide (CNA) was being too fast during guests transfer from bed to wheelchair. The CNA stated she was only holding the Hoyer sling to help navigate the guest's position during the transfer. Corrective action was taken and FM1 was reassured that the staff mentioned will be educated on proper handling when transferring guests. Performance correction notification form reviewed. Verbal correction provided to the CNA on 07/22/25. Resolved on 07/22/25. Electronic Health Record (EHR) reviewed for R58 on 01/14/26. R58 is an [AGE] year-old female admitted to the facility on [DATE]. Diagnosis includes and is not limited to unspecified dementia, Hemiplegia and hemiparesis (weakness on one side) following cerebral infarction (stroke) affecting right dominant side. Nursing progress note dated 01/12/26 at 11:39 AM reviewed. Skin tear to left elbow noted after transferring back to bed. 1 by 0.7 centimeters (cm). Normal Saline (NS), Medi-honey and dry dressing applied. Family made aware, no concerned (sp) verbalized at this time. Physician (MD) made aware via MD binder. Interview with Registered Nurse (RN) 55 on 01/16/2026 at 1:03 PM in the third-floor medication room. Asked about the shower schedule for R58 and what the nursing staff are doing to prevent skin tears during transfers to the wheelchair. RN55 said the CNA's have a schedule for R58's ADL's, her showers are four times per week. We have the preventions in place; she wears the Geri sleeves. Most of the time when transferring her with the Hoyer lift, she screams, it's her behavior. During an interview with the Director of Nursing (DON) on 01/16/2026 at 1:17 PM. Asked him about the care plan interventions for R58's Activities of Daily Living (ADL's) and asked him what the nursing staff are doing to address her hand hygiene and her most recent skin tears. The DON responded that they have made a lot of considerations for R58 at the request of the family. We have increased her shower schedule from 3 times per week to 4 times per week at the request of the family. We are considering trimming her nails. The DON later confirmed that the family was called to inquire about having R58's nails trimmed and declined to have the staff trim them. 2) On 10/16/25 at 4:00 PM, the Department of Health, Office of Healthcare Assurance (OHCA) received a complaint from R185's FM3 that R185 sustained a fall at the facility on 10/03/25. R185 was sent to the hospital post fall and admitted with a diagnosis of a mild fracture of L2 (lumbar 2) that was worsened by the fall. FM3 was contacted by the Charge Nurse (CN) 1 and was told that R185 was up in the wheelchair (w/c) in the hallway for lunch and that resident was left unattended due to CN1 and Certified Nurse Aide (CNA)1 was the only two people on the floor and they were busy assisting another resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/16/26 at 08:00 AM, record review of R185's EHR was conducted. R185 is a [AGE] year-old female that was admitted on [DATE] to the facility with primary diagnosis of other fracture of second lumbar vertebra, with a history of first lumbar vertebra but not limited to, syncope, and unspecified dementia. R185's care plan noted that she is at risk for falls due to decreased mobility, pain, debility, and advanced dementia. One approach noted in the care plan to address falls was to observe R185 frequently and place her in a supervised area when she is out of bed. Review of the facility's investigation summary and witness statements confirmed that R185 was placed in the hallway in her w/c for the afternoon meal with other residents. According to CN1's witness statement dated 10/6/25, R185 was last seen by CNA1 at 16:40 PM. At about 16:45 PM, CN1 was inside the Resident Care Manager's (RCM) office when they heard a visitor from 225A rushing to help R185. Per visitor R185 was found on the floor on her left side curled up. On 01/16/26 at 09:30 AM, interview with CN1 confirmed her statement and acknowledged that R185 was a high risk for fall due to her dementia and should not have been left alone or unsupervised. CN1 stated that prior to her meeting with RCM, CNA1 was in the hallway watching R185 and other residents. CNA1 proceeded to help another resident in their room, thus leaving R185 unsupervised in the hallway. When asked if this fall could have been prevented, CN1 responded yes and that CNA1 should have called for help before leaving hallway and losing sight over R185 and the other residents. CN1 further stated that CNA1 is a part-timer and was not familiar with the residents on the second floor. On 01/16/26 at 1:30 PM, review of the facility's Fall Prevention and Management Program Guidelines, in the Key Elements of the Fall Prevention and Management Program, it notes, E. Re-assessment, implementation and evaluation of treatment plan. In the Details of Key Elements section E of the Dynamic Treatment Plan, it states, 2. As information is updated, it needs to be communicated to the staff.a. Staff. 3. Individual care plan developed, communicated with staff and implemented.