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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure that food items stored in the walk-in refrigerator were labeled properly and old food discarded. This deficient practice places residents in the facility at risk for foodborne illness.Findings Include:During an initial walkthrough of the kitchen with the Dietary Manager (DM) on 01/13/26 at 09:00 AM, in the walk-in refrigerator, observed meatloaf stored beyond the discard date of 12/24, and turkey beyond the discard date of 01/11. A tray of Salisbury steak was observed with an open date of 11/24 and no discard date. Concurrent interview with the DM noted that these items should have been thrown out to prevent serving expired food and residents risking foodborne illness.

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure five out of 10 residents (Resident (R), 112, R182, R177, R179, and R180) sampled for receiving specialized services, received physical therapy (PT) treatments according to their prescribed treatment plan. PT treatments help to assist the residents to restore his/her highest level of physical functioning. This deficient practice affects the resident's ability to meet their therapy goals. Findings Include: Observation and interview with R182 in her room on 01/13/26 at 2:00 PM. R182 said she fell on her front stairs at home and fractured her foot. She said she was getting therapy, but she wasn't supposed to put weight on her foot. Observed R182 lying in her bed, with a blue colored cast on her lower right leg. R182 added that she is concerned about her therapy, because she knows that she will only be allowed for a couple of weeks of therapy then she is supposed to go home. She said her house has stairs, and a narrow hallway, she said she didn't think the wheelchair would fit. When asked if she felt like she was making progress she added that she wasn't sure because each time she had therapy, she is doing different exercises and didn't feel like the exercises were consistent. Electronic Health Record (EHR) reviewed on 01/14/26. R182 is a [AGE] year-old female admitted to the facility on [DATE] for rehabilitative services. Minimum data set (MDS) admission assessment dated [DATE]. Functional status: Substantial/ Max assist. PT evaluation & plan of treatment note reviewed. Certification Period: 1/5/2026 - 2/3/2026 Start of Care: 1/5/2026. Reason for Referral: Patient is a [AGE] year-old female who presented to the hospital following a fall on her right side. She was unable to WB (weight bear) following a fall. She was found to have right fibula fracture. She underwent surgeries to repair the fractures on 12/26 and 12/30. Present level of function: Lives with family in a 2-story house. Assessment summary. Reason for therapy. Patient requires PT services to facilitate independence with all functional mobility.Plan of treatment. Therapeutic exercises.Frequency: five times per week, for 30 days, daily. Potential for achieving rehab goals: Patient demonstrates good rehab potential as evidenced by ability to follow 2 step directions, able to make needs known, motivated to participate and motivated to return to prior level of living. Anticipated help needed upon discharge: Patient will likely require assist from caregiver or family upon discharge. Physician orders reviewed. 01/05/26 – 02/03/26 PT evaluate and treat 5x/week for 30 days. Treatment may include therapeutic exercises, therapeutic activities. Reviewed progress notes for PT visits on 01/16/26. Noted missed PT visit for week 01/05/26 to -1/10/26. Resident encountered four of five PT visits. Requested documentation for missed PT appointment from the Director of Rehab (DOR). Received and reviewed the Service Log Matrix with date range of 01/01/2026 to 01/31/2026. Confirmed R182 had four visits from 01/05/26 to 01/10/26. Reviewed PT missed visit details dated 01/10/26 Reason for missed session: Cancelled. Signed by PT 15 at 01/12/26 at 3:14 PM. The DOR stated that PT15 wasn't working and not available for interview to determine why the appointment was cancelled. 2) R112 was an [AGE] year-old resident admitted to the facility on [DATE] for short-term rehabilitation services. Diagnoses included but not limited to hyponatremia (low sodium level in the (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood) and general weakness. On 01/13/26 at 09:23 AM, an interview was conducted with R112 in her room. Queried R112 about her PT services at the facility. R112 said she has not had any PT sessions since 01/09/26. When asked how often she was getting PT before 01/09/26, R112 said she used to get PT every day and was not sure why it stopped. Review of R112's Electronic Health Record (EHR) was conducted. Scanned document titled Physical Therapy, PT Evaluation & (and) Plan of Treatment dated 12/16/25 stated under Plan of Treatment a frequency for PT services of five times a week for 30 days. On 01/16/26 at 11:22 AM, concurrent interview and record review was conducted with the DOR in the conference room. PT service log for January 2026 indicated that R112 did not have PT for five consecutive days from 01/09/26 to 01/13/26 and was seen only two times for the week of 01/11/26 to 01/17/26. The DOR confirmed the frequency of PT services was not met for the current week and will further investigate. On 01/16/26 at 1:01 PM, the DOR presented a document titled Physical Therapy Missed Visit Detail that stated, 01/12/26 Reason for Missed Session: Scheduling Conflict. No other information to explain the scheduling conflict was noted. The document was electronically signed on 01/16/26. 3) On 01/13/26 at 2:26 PM, observed R177 in bed, with his family member at the bedside and voiced that he should be receiving PT daily but has not been getting it daily and is waiting for his next treatment. R177 noted that he was evaluated by someone but had only one treatment since then. On 01/16/26 at 12:33 PM, record review of R177's Electronic Health Record (EHR) noted that R177's PT evaluation was completed on 01/07/26. The PT plan of care indicated that R177 should be receiving PT at the frequency of five times/week for 30 days. The PT service log noted that R177 did not receive PT treatment on 01/12/26. On 01/16/26 at 01:50 PM, interview with the DOR who confirmed that R177 did not receive a PT treatment on 01/12/26 and did not meet the 5x a week for the week of 01/08/26-01/14/26. The DOR further stated that the treatment was missed due to a scheduling conflict but was not sure of what it was. The PT missed visit details noted that it was just signed by the DOR on 01/16/26 at 4:50 PM. 4) On 01/14/26 at 10:14 AM, observed R179 in his room sitting down on his wheelchair eating breakfast. When asked if he had any concerns, he stated that he has had only one PT treatment and that he should be getting it at least four times a week. R179 also stated that the facility was supposed to provide him with a walker, but until now, they have not provided it. On 01/15/26 at 10:18 AM, record review of R179's EHR noted that he had his PT evaluation on 01/07/26. The PT treatment plan indicated that R179 should be getting PT treatments five times a week for 30 days. R179's PT service logs showed that he did not receive PT treatment on 01/13/25, which would have been his fifth treatment for the week of 01/07-01/13/26. The PT missed visit detail report noted the reason for the missed session was due to dialysis. R179 is getting dialysis treatments three times a week on a Tuesday, Thursday, Saturday schedule. 01/13/26 was a Tuesday, R179's regular scheduled dialysis day. The facility was able to accommodate R179's PT treatments on his other regular scheduled dialysis days the previous week. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/14/26 at 1:50 PM, interview with the DOR noted that she was not sure why the PT treatment was not done on 01/13/26 and stated the physical therapist assigned was off that day so she was not available for an interview. 5) On 01/14/26 at 11:03 AM, observed R180 on her wheelchair waiting for lunch. When asked if she had any concerns, R180 voiced that she is not where she wants to be. She elaborated that she is still not able to walk up any steps yet, which she would have to do at home. R180 was told that she would be discharged sometime this week but feels she needs more PT to be able to function at home. On 01/16/2026 at 12:19 PM, record review noted on PT evaluation and treatment plan that resident should be receiving PT treatments five times a week. During week of 01/5-1/10/26, R180 only had four treatments, with 01/10 not being done. The missed treatment rationale indicated cancelled. Interview with the DOR could not elaborate on the reason why it was cancelled and stated Physical Therapist assigned to complete treatment was not available for an interview.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interview, the facility failed to ensure the risk and benefits of using psychotropic medications were explained and documented for two of five Residents (R) 162 and R181 or their representatives sampled for unnecessary medications. This deficient practice affect's the residents' ability to understand the risks or benefits of treatment. Findings include:1) R162 was a [AGE] year-old resident admitted to the facility on [DATE] for short-term rehabilitation services. Diagnoses included but not limited to Alzheimer's disease, delirium due to known physiological condition, restlessness and agitation, and dementia.Review of R162's Electronic Health Record (EHR) was done. Cognitive screening was done on 01/05/26 and noted R162 had BIMS (Brief Interview for Mental Status) score of 3, indicating severe cognitive impairment. R162 had orders for Olanzapine (antipsychotic medication) 5 mg (milligrams) and Trazadone (antidepressant medication) 50 mg once a day. Review of the consent form completed on 01/02/26 revealed that verbal consent was obtained for the use of both medications. The consent form did not include the name of the consenting individual, their relationship to the resident and the date consent was obtained and there was no documentation in the progress notes. 2) R181 was an [AGE] year-old resident admitted to the facility on [DATE] for short-term rehabilitation services. R181 has a medical history that included, but not limited to, dementia and Alzheimer's disease, and delirium due to known physiological condition.Review of R181's EHR was conducted and noted that R181's BIMS score on 01/08/26 was 3, indicating severe cognitive impairment. R181 had a medication order for Quetiapine (antipsychotic medication) 50 mg at bedtime. Review of the consent form for the antipsychotic medication dated 01/07/26 revealed that verbal consent was obtained, however, the name and relationship to the resident of the consenting individual and date it was obtained were not documented. No progress notes that identified who the facility obtained consent from were found in the EHR.On 01/16/2026 at 12:26 PM a concurrent interview and record review was conducted with the Resident Care Manager (RCM) 6 at the nurses' station. Reviewed the consent forms for the use of psychotropic medications for both R162 and R181. Queried the RCM who would the facility get consent from if the residents are not able to due to cognitive impairment. RCM said they would ask the family members or authorized representatives to sign the consent. RCM acknowledged that the consents for both R162 and R181 were documented as verbal but does note who gave the verbal consent. RCM added, It's hard to validate if the name is not there, staff must type the name in the consent form. Review of the facility policy titled Use of Psychotropic Medications(s) with a revision date of 02/13/25 stated, .Prior to initiating or increasing psychotropic medication, the resident/guest, family, and/or resident/guest representative must be informed of the benefits, risks and alternatives for the medication .

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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.

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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. Based on observations, interviews, and record review, the facility failed to ensure that one of one resident sampled for quality of care received treatment and care in accordance with professional standards of practice and the comprehensive care plan.Findings Include:On 01/14/26 at 09:55 AM, observed Resident (R) 173 in bed with oxygen (O2) on 3L (liter) via nasal cannula (NC). R173 stated her breathing was okay and she had no shortness of breath (SOB), despite having a moist cough.Record review of R173's Electronic Health Record (EHR) on 01/14/26, noted a physician's order for continuous O2 at 1-2 LPM (liters per minute) via NC, Sp02 (oxygen concentration) goal: 88-92%, and to notify Physician (MD) if condition worsens or if requiring additional O2. Review of the progress notes did not indicate the need for O2 to be increased to 3L. During an interview with RN1 on 01/14/26 at 12:30 PM, RN1 verified that R173's 02 was set on 3L. Requested RN1 to review R173's O2 orders in the medical record. RN1 confirmed the current order is 1-2L and there were no orders to increase O2 level to 3L. RN1 stated that the evening shift RN2 endorsed to her that R173's O2 level be on 3L but confirmed that there was no documentation in the progress notes by RN2 of R173 needing to increase O2 level. RN1 also acknowledged that there was no physician notification made to increase O2 level and verbalized the importance of documentation and notifying the physician of any changes to the resident's status.Facility's Oxygen Administration policy dated 10/01/2024 was reviewed on 01/16/26. In the Policy Statement section, it notes, Oxygen is administered to a resident who needs it, consistent with professional standards of practice, the comprehensive care plan. In the Procedure section, it notes, 6. Notify the physician of any changes in the resident's condition, including significant changes in.oxygen concentration.16. The resident's care plan will identify the interventions for oxygen therapy, based on the resident's assessment and orders. Review of the facility's Change in a Resident's Condition or Status policy, dated 12/01/2024, in the Policy Statement section, it notes, This facility's policy is to promptly notify.Attending Physician.of changes in the resident's/guest's medical/mental condition and/or status. In the Procedure section, it notes, The nurse will notify the resident's/guest's Attending Physician or physician on call when there has been I. Specific instruction to notify the Physician of changes in the resident's/guest's condition.2.A significant change of condition is a major decline.the resident's/guest's status that: requires interdisciplinary team review and/or revision to the care plan. Review of the facility's Documentation in Medical Record policy with a revision date of 03/18/2025, in the Policy Statement in notes, Each resident/guest's medical record shall contain an accurate representation of the actual experiences of the resident/guest and include enough information to provide a picture of the resident/guest's progress through complete, accurate, timely documentation. In the Procedures section, it notes, 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care serviced occurred.

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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.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews, the facility failed to ensure the indwelling urinary catheter bag was placed in a sanitary position off the floor for one Resident (R) 65 sampled with an indwelling urinary catheter. The deficient practice increased R65's risk of preventable urinary tract infections. This has the potential to affect all residents with a urinary catheter. Findings include:On 01/13/26 at 12:26 PM, observed R65 lying in bed with his eyes closed. R65 was using an air mattress and had an indwelling urinary catheter. R65's bed was set at the lowest setting. The urinary catheter line was connected to a urine collection bag on the left side of the bed. The urinary catheter line and urine collection bag were on the floor. Registered Nurse (RN) 9 was in the hallway by the medication cart. Asked RN9 to check on R65's urine collection bag. RN9 confirmed that the bag was on the floor and that it was supposed to be placed in a basin to act as a barrier so that it is not touching the floor.Review of R65's Electronic Health Record (EHR) conducted. R65 was a [AGE] year-old resident admitted for short-term rehabilitation services. Diagnoses included, but not limited to, sepsis (a life-threatening, emergency response to infection where the immune system damages the body's own tissues and organs), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body), and urinary tract infection. Review of the care plan dated 12/07/25 noted one of the interventions for the indwelling urinary catheter stated, Do not allow tubing or any part of the drainage system to touch the floor.Review of the facility policy titled Indwelling Urinary Catheter Care with a revision date of 10/05/25 stated, . Be sure the catheter tubing and drainage bag are kept off the floor.

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility failed to securely store a medication patch for one of one resident sampled for medication storage; and 2) discard a medication injectable for a resident who was no longer residing in the facility in one medication room of two medication rooms sampled; and 3) label a medication bottle without an open date in one medication cart of six carts in the sample. The deficient practice increases the risk of a medication diversion.Findings include: During an observation in Resident (R) 58's room on 01/14/2026 at 09:12 AM, an opened and labeled lidocaine patch was placed on the resident's mattress at the foot of the bed. R58 was lying in bed awake. Asked R58 if she is having any pain and she said, not now. I did have pain earlier. At 09:23 AM asked Licensed Practice Nurse (LPN) 30 if R58 was supposed to get a lidocaine patch during the medication rounds. LPN30 looked in the Electronic Health Record (EHR) and said oh no, I went into the room to put it on then I got called out of the room for something else and forgot to go back and put it on. I should have put it on first. 2) Observation on 01/15/2026 at 08:20 AM in the Fifth-floor medication room with the Infection Preventionist (IP). Inspection of the medication refrigerator revealed an insulin pen. Review of the label revealed Toujeo Max Solostar (Insulin), the label appeared worn and the name of the resident was not legible. Asked the IP if she could identify the name of the resident and if so, if they were still residing in the facility. The IP looked in the EHR for the resident and said she thought they were discharged and would get back to the surveyor. At 09:35 AM the IP confirmed the resident was discharged and the insulin pen should have been discarded. 3) On 01/15/26 at 08:31 AM, concurrent inspection of medication cart two and interview with LPN3 was done. Observed an opened, one-quart bottle of Lactulose (prescription laxative) in the third drawer of the medication cart. The bottle was approximately two-thirds full, and open date was not noted on the bottle. LPN3 acknowledged that the bottle did not have an open date and added it should have been written on the bottle. Queried LPN3 how long are the medications good after opening. LPN3 responded, It is good for one year after opening but would not be able to tell if there is not an open date.