STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalakaua Gardens	1723 Kalakaua Avenue Honolulu, HI 96826

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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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to assure the kitchen followed dishwasher manufacturers guidelines for sanitizing their dishware and utensils, failed to label beverages with the opened-on date once they were opened, failed to label prepared vegetables and grated cheese with the prepared-on date and failed to throw away meats by the facility's discard by date. The deficient practice puts all residents who eat their meals at the facility at risk for foodborne illness. On 02/17/26 at 09:20 AM initial tour of the kitchen started with [NAME] (C) 9. Inquired about the facility dishwasher logs which C9 was able to provide. Reviewed the dishwashing/warewashing machine temperature log which states For High Temperature Machine: (Refer to machine data plate for temperature requirements). Review of the temperatures logged by facility staff for Final Rinse Temp ranged from 110-185 degrees Fahrenheit from 02/09/26 - 02/17/26. Observation of the dishwasher at this time revealed it was a Model ADC-44, Multi-tank, rack conveyor dishmachine manufactured by American Dish Service Corporation. Review of the thermometers on this dishwasher found the final rinse thermometer had a sticker that stated, Final Rinse 180 degrees Fahrenheit. The NSF Data Plate on the dishwasher states NSF Operational Requirements for Model ADC-44, Multi-tank, rack conveyor dishmachine manufactured by American Dish Service Corporation:Hot water sanitizing Final sanitizing rinse minimum temperature: 180 degrees FPumped rinse tank minimum temperature: 160 degrees FWash tank minimum temperature 159 degrees FFinal rinse minimum pressure: 20 psi Maximum conveyor speed: 6.7 ft./min.Interviewed Dishwasher (DW) 11 in the kitchen. Inquired how he can tell the temperature of the dishwasher that he logs, and he stated he writes the temperature from the thermometers on the dishwasher. Inquired about test strips that are run through the dishwasher, and DW11 stated they do not do use those. At this time the Dining Services Director (DSD) was asked when the logs are reviewed and he stated the end of the month. Inquired if they use test strips to check the water temperature of the dishwasher and he stated, It's a new machine. Inquired if the vendor had explained how to use the temperature strips to assure the dishwasher was reaching the temperatures needed to sanitize the dishes and utensils and DSD said no. Reviewed with the DSD the final rinse temperatures that were logged and showed most of the temperatures logged did not reach the 180 degrees needed to sanitize the dishware. Inquired if he had been notified of the temperatures not reaching 180 degrees for the final rinse and he said no. Continuation of the initial kitchen tour found food items (sliced mushrooms, loose spinach, grated cheese, chopped red bell peppers, chopped tomatoes and chopped onions) uncovered in the refrigerator that was not labeled with the date the food was prepped. Found two large containers of meat (chopped Portuguese sausage and chopped ham) dated 2/9. Inquired of DSD how long they can keep meat like this and he said one week. DSD stated these should have been thrown away. Found a container of orange juice and soy milk that was opened and not labeled with a date when these were opened. Inquired of DSD how long these items can be kept once opened and he stated the vendor told him till the expiration date. Reviewed the soymilk container and shared the following that was printed on the container Shake Well. Refrigeration not needed before opening. Once opened, refrigerate 7-10 days. On 02/19/26 at 10:45 AM went to observe trayline. Requested to review temperature logs and DSD (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated they test the temperature of the food but do not log this information. Interviewed a dietary aide and inquired what the temperature of the food has to be on the trayline and he stated 160 degrees. On 02/19/26 at 11:30 AM interviewed the Administrator in his office. Inquired if he would expect the kitchen staff to log the temperature of the foods on the trayline and he confirmed he would expect the kitchen to have logs of the temperature checks for the trayline for all the meals. Requested facility policy on food safety and Administrator was able to provide this.Review of facility policy titled, Food Safety Requirements states .Policy Explanation and Compliance Guidelines: .3. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/ receipt and ensure timely and proper storage.c. Refrigerated storage - foods that require refrigeration shall be immediately upon receipt or placed in freezer, whichever is applicable. Practices to maintain safe refrigerated storage include: .iv. Labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded; andv. Keeping food covered or in air tight containers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to ensure that 2 of 2 ice and water machines for the residents were kept in clean and sanitary conditions in accordance with professional standards for food service safety. Unsanitary food handling and/or equipment maintenance practices represent a potential source of pathogen exposure for all residents receiving ice or water on the affected resident units. Findings include:On 02/17/26 at 10:35 AM, observed a buildup of hardened dark brown sediment/material around the bottom edges of the plastic chute dispensing ice and water from the ice/water machine located on the 4th floor dining room. On 02/18/26 at 08:33 AM, observed the same ice/water machine in the 4th floor dining area with the same buildup of hardened dark brown sediment/material around the bottom edges of the plastic chute. On 02/18/26 at 08:37 AM, interviewed the Director of Nursing at the ice/water machine located on the 4th floor dining area. The DON stated that the ice/water machine is used by residents, staff, and visitors. The DON confirmed the presence of hardened dark brown sediment/material around the bottom edges of the plastic chute and stated that it was not clean. The DON also stated that the Maintenance was responsible for cleaning the ice/water machine.On 02/18/26 at 08:44 AM, met with the Environmental Services Manager (EVSM) and DON at the ice/water machine located in the 4th floor dining room area. The EVSM stated that the housekeepers cleans the drip tray and front portion of the ice/water machine but not way inside. On 02/18/26 at 08:53 AM, observed hardened dark brown sediment/material around the bottom edge of the plastic chute dispensing ice and water from the ice/water machine located on the 5th floor dining room.On 02/19/26 at 06:40 AM, the EVSM confirmed the presence of hardened dark brown sediment/material around the bottom edges of the plastic chute dispensing ice and water from the ice/water machines located on the 4th and 5th floor dining rooms. The EVSM also stated there was no cleaning log for both the 4th and 5th floor ice/water machines.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure respiratory equipment was maintained within professional standards of practice for 4 of 4 Residents (Resident (R) 12, R24, R26, and R45) sampled for Respiratory/Tracheostomy care and suctioning. The facility failed to label and properly store oxygen, nebulizer, and suction equipment. The deficient practice placed the residents at risk of infections and illness. Findings include:1) On 02/17/26 at 10:03 AM and 02/18/26 at 08:21 AM, the following was observed in R12's room: -Undated humidifier bottle with undated tubing connected to an oxygen concentrator. -Uncovered oxygen tubing connected to an oxygen tank located on the side of R12's bed. -Uncovered yankauer suction tip catheter attached to suction tubing and connected to the suction machine was hanging down from the suction machine and leaning against R12's bedside dresser drawer. On 02/19/26 at 01:32 PM, a review of R12's physician orders noted active orders stating, Suction orally prn [as needed] for increased secretions and O2 [Oxygen] 1-4 L [Liters] per NC [Nasal Cannula] for SOB [Shortness of Breath]. 2) On 02/17/26 at 07:52 AM and 02/18/26 at 08:27 AM, observed an uncovered mask with attached medication chamber and undated tubing connected to the nebulizer machine located on the top of R45's bedside dresser. On 02/19/26 at 01:45 PM, a review of R45's physician orders noted an active order stating, Ipratropium-Albuterol Solution 0.5-2.5 (3) MG [milligrams]/3ML [milliliters]. 3 ml inhale orally every 4 hours as needed for SOB [shortness of breath] or Wheezing. Administer for 10-15 minutes via nebulizer. Rinse after administration. 3) On 02/17/26 at 10:57 AM and 02/18/26 at 08:29 AM, observed an uncovered and dry nebulizer mask with medication chamber on a paper towel next to the nebulizer machine with uncovered tubing attached on R24's bedside dresser. On 02/19/26 at 01:49 PM, a review of R24's physician orders noted actives orders stating, Sodium Chloride Inhalation Nebulization solution 7% 1 ml inhale orally via nebulizer one time a day for Asthma, and Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg/3ml.1 vial inhale orally every 4 hours prn for SOB. On 02/18/26 starting at 02:07 PM a walkthrough of R12, R24, and R45's room was done with the DON who stated: -For R12: The humidifier bottle should have been discarded. The humidifier connection tubing should have been dated. The humidifier connection tubing, oxygen tubing and mask, and yankauer suction tip catheter and tubing should have been stored in a plastic bag. -For R24 and R45: The nebulizer equipment (mask and medication chamber) should be washed after use and air dried. Once the equipment is dry, it should be stored in a plastic bag. A facility policy titled, Respiratory: Nebulizer Therapy with a review date of January 2026 stated, Care of the Equipment.4. Rinse the nebulizer cup and mouthpiece with sterile or distilled water.6. Air dry on an absorbent towel. 7. Once completely dry, store the nebulizer cup and the mouthpiece in a ziplock bag. 8. Change nebulizer tubing weekly. Another facility policy titled, Oxygen Administration (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with a review date of January 2026 stated, Policy Explanation and Compliance Guidelines.5. Staff shall.a. Change oxygen tubing and mask/cannula weekly.c. Change humidifier tubing and delivery devices weekly.d. Keep delivery devices covered in plastic bag when not in use. 4) Observation in R26's room on 02/17/2026 at 09:47 AM. R26 was asleep in bed. On the left side of the bed on the nightstand, observed a suction cannister with clear secretions inside with tubing connected to a yankauer (small device used to suction the mouth). The yankauer was placed in a wrapper inside of the nightstand drawer. There was no label with a date when it was placed. Interview with Registered Nurse (RN) 17 on 02/20/2026 at 09:25 AM in the nurse's station. Asked RN17 if R26 requires the use of the suction machine. RN17 said the certified nurse aides (CNAs) use the yankauer to suction her mouth when they are providing oral care. Asked her when the tubing is changed and whether they label it with the date when they change it. She said she would change it on Monday, and yes, they should be putting a label on it when it is changed. Observation in R26's room on 02/202/26 at 09:45AM. Inspected the suction equipment with RN17 and verified that there wasn't a label placed on the tubing or on the yankauer wrapper with a date.

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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. Based on interview and record review the facility failed to inform 1 of 5 residents (Resident (R) 2), of the risk and benefits of taking an antidepressant medication for his insomnia. The deficient practice could affect all residents in the facility who are not informed in advance of starting an antidepressant of the risks and benefits and offered other treatment alternatives or options. On 02/19/26 at 09:12 AM during record review of R2's Electronic Health Record (EHR) found R2 was ordered Trazodone HCL 50 mg one tablet by mouth at bedtime for insomnia. Review of R2's consents and progress notes did not reveal documentation that R2 or his representative was informed in advance of the risks and benefits of this medication or treatment alternatives that he could choose.On 02/19/26 at 10:00 AM requested of Director of Nursing (DON) documentation that the facility reviewed the risk and benefits of Trazodone with R2 or his representative.On 02/19/26 at 04:30 PM DON confirmed she could not find any documentation that facility staff reviewed the risks and benefits with R2 or his representative of taking Trazodone and this should have been done.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to provide clean personal care equipment and living space for 1 of 13 residents (Resident (R) 26) sampled for a clean environment. The deficient practice placed the resident at risk for discomfort and illness. Findings include: Resident (R) 26's room was observed on 02/17/26 at 09:47 AM. R26 was asleep in her bed and observed an Oxygen (O2) concentrator that was not being used in the corner next to the bed. Upon closer inspection observed dust on the top of the unit. In the same area, thick dust was observed on the wall behind the resident's headboard. On the left side of the bed on the nightstand, observed a suction cannister with clear secretions inside and tubing connected to a yankauer (small device used to suction the mouth) without a date or label. No date or time written on the wrap or the tubing. Registered Nurse (RN) 17 was interviewed on 02/20/2026 at 09:25 AM in the nurse's station and was asked if the O2 concentrator is for R26. RN17 said, Yes, she's receiving Hospice care. Asked if R26 uses it and she said, No she hasn't ever used it. The Hospice ordered the concentrator, and the medical supplier brought it to the resident's room. Asked RN17 who is responsible for cleaning the machine and providing the maintenance. She said, We can clean it if it's dusty and the medical supplier will provide necessary maintenance. Observation with RN17 in R26's room. Inspected the care equipment and wall behind the headboard and verified there was heavy dust.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 5 residents (Resident (R) 3) sampled for unnecessary psychotropic medication was not prescribed as needed (PRN) anti-psychotic medication for greater than 14 days. The deficient practice placed the resident at risk for an adverse event. Findings include:Electronic Medical Record (EMR) reviewed on 02/19/26. Resident (R) 3 is an [AGE] year-old male admitted to the facility on [DATE]. Resident is taking Quetiapine (an anti-psychotic medication) for his diagnosis of Parkinsons and non-Alzheimer's dementia. Reviewed the Medication Regimen Review (MRR) dated 01/31/26. Note to attending physician/ prescriber with recommendations to order PRN for no more than 14 days and then reassess. The physician (MD) agreed and wrote the order for 30 days. It was signed and dated 02/05/26.Physician orders reviewed. Quetiapine Fumarate oral tablet 25 milligrams (MG); Give 0.5 tablet by mouth every 12 hours as needed for mild hallucinations for one month and give 1 tablet by mouth every 12 hours as needed for moderate to severe hallucination for one month.Minimum Data Set (MDS) with an assessment reference date (ARD) of 01/04/26 reviewed. R3 is severely cognitively impaired and did not have any delusions, hallucinations or behaviors that were coded on the assessment. R3 was coded as behavior was improved since the last assessment. Care Plan Reviewed, revised 01/13/2026. R3 is receiving anti-psychotic medication as ordered thus is at risk for experiencing possible complications. Director of Nursing (DON) interviewed on 02/19/2026 at 03:51 PM in the conference room.Asked the DON what is the process for the medication regimen review. The DON explained the pharmacy consultant reviews the Drug regimen every month. If there is a recommendation, he sends a copy of it out via email to medical records, the DON and the Medical Director. If there are recommendations for nursing or the practitioner, the DON carries it out and puts it in the binder for that resident's Physician. The physician reviews the recommendation in the binder and writes the order. The order for the prn use of quetiapine for 30 days was discussed with the DON who stated the provider was adamant about re-evaluating the effectiveness of the antipsychotic medication after 30 days. Telephone call to the Pharmacy Consultant (PC) on 02/19/2026 at 03:59 PM. Asked the PC if the order for 30 days was correct. The PC said the recommendation to the physician was to order the prn quetiapine for no more than 14 days and re-evaluate the need for the prn medication. Explained to the PC that the DON reviewed the recommendation written by the physician and carried out the order in the Residents record. Psychotropic Medications policy with a review date of 12/2025 stated, Page 3. b. PRN orders for antipsychotic medications only, shall be limited to 14 days with no exceptions. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to implement resident centered activities based on the resident's interests for 1 of 2 residents (Resident (R) 44) sampled for activities. This deficient practice failed to enhance the Resident's sense of well-being of watching news and sporting events on the television. Findings include: Observed Resident (R) 44 in her room in bed on 02/17/2026 at 10:35 AM. The television (TV) was off and the room was quiet. R44 was non-verbal and smiled. Random observations made on 02/17/26 and 02/18/26, observed R44 in her room in bed with the TV off and the room quiet while awake. Family member (FM) 10 was sitting at the bedside and interviewed on 02/19/2026 at 10:33 AM. Asked how often she visits R44. FM10 said, My husband visits her more often. When asked how R44 is doing, she answered, Ok, but I wish we could turn the TV on for her. I think there is something wrong with the remote. I asked the nurse and she said she would ask for maintenance to look at it. She [R44] really does seem to engage with the TV.Minimum data set (MDS) with an assessment reference date (ARD) of 05/30/25 reviewed. R44 is cognitively impaired and dependent on staff for her care. It is very important to R44 to keep up with the news and somewhat important to listen to music that she likes. Care plan dated 04/15/25 reviewed which listed that R44 enjoys one to one (1:1) room visit from staff to talk. She enjoys independent activities like listening to music and watching TV.Social services note dated 02/13/26 reviewed. Nephew asked to put in a work order for resident's TV because he notices she seems to enjoy watching sports and follows along with the TV, but not always able to work it. Medical Social Worker (MSW) followed up with maintenance to check on the status of her TV. MSW to follow up as needed. Observation and interview with Registered Nurse (RN) 17 on 02/20/26 at 07:45 AM in R44's room during a medication administration observation. RN17 looked up at the TV that was off and asked R44 if she would like to watch TV. RN17 went to the TV and reached behind it to turn it on. The channel was on the sports channel with a Volleyball match and R44 smiled at RN17. RN17 said that R44 likes to watch sports channels. Interview with the Activity Director (AD) on 02/20/2026 at 02:15 PM in the conference room. Asked the AD what type of activities does R44 like to do. The AD said, Most of the time she just stays in her room. She doesn't really talk. When asked if she ever comes out of her room she replied, Sometimes, she comes out when the certified nurse aides (CNA's) change her bedding. Mostly she just listens to music, and I talk to her and keep her company. She gets excited when someone comes into her room. When asked if R44 likes to watch TV, the AD responded, She likes sports. Explained to the AD that the niece was visiting and said that she likes to watch TV and it has not been working. The AD said, The TVs are wonky sometimes. Asked her what the process is to put in a work order to fix the TV. The AD said, It's probably faster to call maintenance.Reviewed the Activity Participation 1:1 task flow sheet dated 01/22/26 to 02/17/26. Music and TV/ Video were listed on the form, but talking & repositioning was the only column checked on each day. Quality of life activities policy revised 12/2025 was reviewed and stated, Guidelines: 2. Activities will enhance the physical, cognitive and emotional health of the residents. 4. The activity program consists of individual and may include the following: Music .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not correctly transcribe the physician orders for the splints/braces to the Medication/Treatment Administration record (MAR/TAR), did not ensure staff were trained on the application of physician ordered splints/braces, and did not follow-up on therapy recommendations for a palm splint for 1 of 3 residents (Resident (R) 37) sampled for limited range of motion (ROM). This deficient practice hindered R37's ability to maintain the highest practicable well-being and has the potential to affect all residents at the facility who have limited ROM. Findings include:Resident (R) 37 is a is a [AGE] year-old male with a diagnosis of left hemiplegia following cerebral infarction. A Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/25 noted R37 requires dependent care (resident does none of the effort to complete the activity) for his activities of daily living (ADL).On 02/17/26 at 10:10 AM, observed R37 sleeping in bed with left arm and leg bent. Two braces were seen on the top of R37's shelf near the bedside.1) On 02/19/26 At 03:42 PM, a review of R37's physician's orders and February 2026 MAR/TAR were done. The following active orders were noted:-04/28/23 order and start date: Knee brace. Apply brace to left knee for 2 hours every shift for contractures. Remove brace after 2 hours. This order was transcribed to the February 2026 MAR/TAR and being signed off by the Licensed Nurses.-04/28/23 order and start date: Apply brace to left elbow for 2 hours every shift for contractures. Remove after 2 hours. This order was transcribed to the February 2026 MAR/TAR and signed off by the Licensed Nurses.-03/05/24 order date and 03/07/24 start date: Apply elbow orthosis splint on left upper extremity every day shift, every Tuesday, Thursday, Saturday for contracture of left arm. This order was transcribed to the February 2026 MAR/TAR and signed off by the Licensed Nurses.-03/05/24 order date and 03/07/24 start date: Remove elbow orthosis splint on left upper extremity after 3.5 hours every day shift, every Tuesday, Thursday, Saturday for contracture of left arm. This order was transcribed to the February 2026 MAR/TAR and signed off by the Licensed Nurses.-03/08/24 order date: Patient to wear left knee contracture splint 3 times a week for total of 4 hours (2 hours on/2 hours off/repeat). Can be worn on same schedule as left upper extremity splint. This order was not transcribed to the February 2026 MAR/TAR.On 02/20/26 at 08:06 AM, Registered Nurse (RN) 16 was interviewed on the 4th floor at medication cart B. RN16 stated that the left elbow and knee splint for R37 are both applied daily in the daytime for 2 hours and that the splint and brace are the same equipment.On 02/20/26 at 09:54 AM, the Director of Nursing (DON) was interviewed in her office with a concurrent review of R37's Order Summary report and MAR/TAR. The DON confirmed that the 03/05/24 order for the left elbow splint and 03/08/24 for left knee splint were the current orders and should have replaced the 04/28/23 left elbow and left knee brace orders on the MAR/TAR. 2) On 02/20/26 at 08:24 AM, the Therapy Director (TD) was interviewed in her office. The TD stated that training on recommended equipment by therapy is done by therapy staff with the Restorative Nurse Assistant (RNA) or Nurse on duty that is in charge at the time if the RNA is not available. TD also stated that the DON would be the one to ask about training of additional nursing staff.On 02/20/26 at 09:54 AM, the DON was interviewed in her office. The DON stated that the splint recommendations for R37 would have been trained by therapy staff with the RNA or Nurse on duty at the time. Training with additional nursing staff would be done utilizing a train the trainer method. However, documentation of splint training with additional staff could not be provided.3) On 02/20/26 at 08:24 AM, the Therapy Director was interviewed in her office. The TD stated that R37 received occupational therapy starting on 01/12/26 and ending on 02/06/26. A Therapy to Restorative Nursing Communication form dated 02/16/26 was prepared by Occupational Therapist (OT) 1 which listed recommendations for a left palm splint to be put on for up to 8 hours daily. The form was signed off by RN11 on 02/16/26 as receiving instructions. On 02/20/26 at 09:54 AM, the DON was interviewed in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125066	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalakaua Gardens	1723 Kalakaua Avenue Honolulu, HI 96826

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her office with a concurrent review of R37's 02/16/26 Therapy to Restorative Nursing Communication form, order summary report and MAR/TAR. The DON stated that follow-up regarding the left palm splint recommendation was not done with R37's physician and nursing documentation regarding the left palm splint and physician orders to use it was not able to be found.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. Based on observation and interview, the facility failed to ensure that medications in 2 of 4 medication carts were stored and locked in accordance with professional standards. Proper storage of medications and locking of the medication cabinet is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility who take medications.Findings include:1) On 02/19/26 at 07:43 AM, the 4th floor medication cart B was inspected with Registered Nurse (RN) 16 present. In the first drawer of the medication cart: -Three individually sealed capsules of Vancomycin Hydrochloride 125mg and one individually sealed capsule of Cephalexin 250mg was found in a container that also contained sealed Acetaminophen and Bisacodyl suppositories. The individually sealed capsules were not stored in a bag/packaging containing the following minimum information: Medication name (generic and/or brand), prescribed dose, strength, the expiration date when applicable, the resident's name, and route of administration. RN16 stated he did not know which resident(s) the Vancomycin and Cephalexin capsules were prescribed for, why is what stored individually in the container, and stated that the medications should have been discarded. -In another compartment of the first drawer of the 4th floor medication cart B, two individually sealed capsules of Midodrine 2.5mg was found in a medication cup. RN16 stated that on the evening shift of 02/18/26 an order was received to start Midodrine 2.5mg 1 tab three times a day for Resident (R) 54. On 02/18/26, RN16 pulled 3 doses from the automated medication dispensing cabinet and stated one dose was administered the for the scheduled evening dose on 02/18/26. The other 2 doses were pulled for the morning and afternoon doses on 02/19/26 because delivery of the medication was not going to occur until the evening of 02/19/26. RN16 acknowledged that it was not good practice to pull multiple doses from the automated medication dispensing cabinet and store it in the medication cart because there was no labeling for which resident it was for and no labeled instructions regarding administration of the medication. On 02/19/26 at 10:17 AM, the Director of Nursing (DON) was interviewed in her office. The DON stated that the individually sealed Vancomycin and Cephalexin capsules found in the medication cart should have been discarded. The DON also stated that the amount of medication pulled from the automated medication dispensing cabinet should only be for the dosage that is due at the time and extra doses should not be pulled and stored in the medication cart. 2) On 02/17/26 at 01:07 PM observed a medication cart on the 4th floor was left unlocked. Registered Nurse (RN) 7 was asked if the medication cart is supposed to be locked and RN7 confirmed it was left unlocked and it should have been locked before she left it. On 02/20/2026 at 10:51 AM interviewed the Director of Nursing (DON) in the conference room and inquired if medication carts are to be locked before nurses leave them. DON confirmed the nurses are to lock the medication cart before leaving the medication cart.

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	125066	A. Building B. Wing	02/20/2026

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, therapy services failed to follow physician ordered restrictions for 1 of 3 residents (Resident (R) 7) sampled for limited range of motion. This deficient practice had the potential to lead to worsening injury to R7.Findings include: On 02/19/26 at 02:32 PM, R7's records in the Electronic Health Record (EHR) were reviewed. R7 re-entered the facility from the hospital on [DATE] with a diagnosis of unspecified fracture of left femur with non-operative management. A physician's order dated 02/26/25 stated non-weight bearing (NWB) and no range of motion (ROM) every shift for left distal femur fracture. On 02/20/26 at 08:43 AM, an interview was conducted with the Therapy Director (TD) in her office. The TD stated that R7 received physical therapy that spanned from 04/29/25-06/27/25 and ROM was being done to R7's bilateral lower extremities (ankle, knee, and hip). The TD confirmed that during the span of therapy, no new order was received since the 02/26/25 initial order for NWB and no ROM for R7. After therapy ended on 06/27/25, recommendations from therapy were written on the Therapy to Restorative Nursing Communication, dated 06/27/25, for Everyday ROM. The TD confirmed that the recommendation should have included more specific information on which extremities ROM was to be done.On 02/20/26 at 11:34 AM, the TD was interviewed in her office with concurrent review of R7's physical therapy treatment encounter notes printed from the electronic health record. The TD again confirmed that the current physician order stating NWB and no ROM to R7's left was 02/18/25. The TD also stated that the physician orders should have been checked for any restrictions before therapy was initiated and that the physical therapy notes from 04/29/25 -06/27/25 had charting of movement performed to R7's left leg in the form of stretches and active and passive ROM.