STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Islands Skilled Nursing & Rehabilitation	1205 Alexander Street Honolulu, HI 96826

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain a copy of the resident's Advance Health Care Directive (AHCD), did not inform the resident of his/her right to develop an AHCD and/or provide assist in doing so, and was unable to provide documentation of physician determination that the resident lacked capacity for decision making in relation to the Declaration of Authority to act as Surrogate for a Patient for 7 of 10 residents (Residents (R) 1, R7, R12, R28, R33, R36, and R38) sampled. This deficient practice does not allow residents, when incapacitated, the right to have their health care choices identified and honored.Findings include: 1) On 04/29/26 at 07:01 AM, A record review of R28's electronic health record (EHR). R28 had a Declaration of Authority to act as Surrogate for Patient document on file. However, the bottom portion of the document titled, Lack of ability Determination for Surrogate Decision Making to be completed by the physician was not done. On 04/29/26 at 04:04 PM, a facility document listing the status for all the requested residents' AHCD was reviewed and confirmed that a physician note of capacity for R28 could not be found in the EHR. On 05/01/26 at 08:51 AM, the Social Worker (SW) was interviewed in his office. The SW stated that when a Declaration of Authority to act as Surrogate for Patient form is initiated, there should be confirmation by the physician that a resident has lack of capacity for decision making. 2) On 04/29/26 at 07:05 AM, a record review of R33's EHR noted R33 was admitted on [DATE] and found no AHCD on file or documentation that R33 and/or responsible party was informed of the right to develop an AHCD. 3) On 04/29/26 at 07:23 AM, a record review of R36's EHR noted R36 was admitted on [DATE] and a signed facility form was marked that the resident had an existing AHCD. A copy of the AHCD could not be found in the EHR. On 04/29/26 at 04:04 PM, a facility document listing the status for all the requested residents' AHCD was reviewed and confirmed that R36 did not have a copy of AHCD on file. On 05/01/26 at 08:51 AM, the SW was interviewed in his office. The SW stated that if a resident has an Advance Directive, he will try to contact the family/responsible party to obtain a copy right away. No documentation of attempts to obtain the AHCD was found in the EHR. A facility policy titled, Residents' Rights Regarding Treatment and Advance Directives, with a date reviewed/revised date of 03/31/2026, stated, 3. Upon admission, should the resident have an (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	advance directive, copies will be made and placed on the chart as well as communicated to the staff. 4. The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities. 4) On 04/29/26 at 09:15 AM, record review of R1's (admitted on [DATE]) EHR found no copy of the AHCD. On 04/29/26 at 04:00 PM, a facility listing the status for all requested resident's AHCD that was provided by the Social Worker (SW) was reviewed and confirmed that R1 did not have an AHCD in place. 5) On 04/29/26 at 09:30 AM, review of R7's (admitted on [DATE]) found no copy of the AHCD. On 04/29/26 at 04:00 PM, a facility listing the status for all requested resident's AHCD provided by the SW was reviewed and noted that R7 already has an AHCD, however the facility will need to request a copy from the family. 6) On 04/29/26 at 09:45 AM, review of R12's (admitted on [DATE]) EHR found no AHDC on file. On 04/29/26 at 04:00 PM, a facility listing the status for all requested resident's AHCD provided by the SW was reviewed and noted that R7 already has an AHCD, however the facility will need to request a copy from the family. 7) On 04/29/26 at 09:50 AM, review of R38's (admitted on [DATE]) EHR found no AHCD on file. On 04/29/26 at 04:00 PM, a facility listing the status for all requested resident's AHCD provided by the facility was reviewed and noted that R7 already has an AHCD, however the facility will need to request a copy from the family.

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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 review of the facility's policies, the facility failed to ensure that food items stored in the refrigerator and freezer were labeled properly and old food discarded by its used by date. The facility also failed to check the temperature of the hot and cold foods prior to being served and accidentally served old, hard-boiled eggs for breakfast. This deficient practice places residents in the facility at risk for foodborne illness.Findings Include:1) On 04/28/26 at 06:30 AM, during the initial walkthrough of the kitchen with Dietary Manager (DM) observed freezer with multiple meat, seafood, and a box of papaya not properly labeled. There were also meat items with a used by date of 04/14/26 that was not discarded. The refrigerator also had a hummus and spinach artichoke dip with a date in of 04/15/26, but no discard date. Also observed in the refrigerator sliced cucumber and hard-boiled eggs with used by date of 04/24/26 that was still in the refrigerator. Concurrent interview with DM noted that they were short of staff and he was out on emergency leave, thus, there was no oversight on the proper labeling and discarding of food items in both the refrigerator and freezer. DM did acknowledge the importance of labeling food items and discarding them on or prior to its used by date to prevent foodborne illness.2) On 04/28/26 at 07:00 AM, observed Kitchen Help (KH) 1, already preparing food for breakfast (tray line). Reviewed the daily temperature log for both the cold/hot foods and noted that there was no temperature check documented for the hot foods. Concurrent interview with KH1 noted that she forgot to enter it on the log. On 04/28/26 at 01:00 PM, reviewed the daily food temperature log for the month of April and noted that there was no temperature check documented for both the cold and hot food that was served for breakfast on 04/05/26, no temperature checks for both hot and cold food that was served for dinner on 04/25/26. On 04/30/26 at 02:00 PM, interview with DM confirmed that for the last six months, staff have missed checking and documenting the food temperatures at least two-three times a month and acknowledge the importance of serving foods at the required temperature. 3) On 04/28/26 at 07:00 AM, observed hard-boiled eggs on the tray line. KH1 was asked if she had cooked a new batch of hard-boiled eggs that morning, KH1 noted that she had used the hard-boiled eggs that were in the refrigerator. When KH1 was asked if she had checked the used by date of the hard-boiled eggs, KH stated she did not. KH1 was informed that the hard-boiled egg that was in the refrigerator had a used by date of 04/24/26 and apologized and for not checking the label.On 04/30/26 at 02:00 PM, interview with DM confirmed that the staff should be discarding food by the used by date and checking the labels to prevent expired food being accidentally served to residents. DM acknowledged that serving food items that are not fresh can cause foodborne illness.On 04/30/26 at 03:00 PM, reviewed the facility's Food Safety Requirements policy with a revised date of 02/27/25 in the Policy section stated, It is the policy to procure food from food sources approved or considered satisfactory by federal, state, and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. The Policy Explanation and Compliance Guidelines section stated, 3. C. Refrigerated storage-foods that require refrigeration shall be refrigerated immediately.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.4. When preparing food, staff shall take precautions.in the food preparation process to prevent, reduce, or eliminate potential hazards.d. Holding-staff shall monitor for food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. Review of the facility's Marking for Food Safety policy, with revised date of 02/19/25 in the Policy Explanation and Compliance Guidelines for Staffing section, stated, 2. The food shall be clearly marked to indicate the date or day by which food shall be consumed or discarded.4. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded.6. The Head cook, or designee, shall be responsible for checking (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the refrigerator daily for food items that are expiring, and shall discard accordingly. Review of the Record of Food Temperatures policy, stated, It is the policy of this facility to record food temperatures daily to ensure food is at the proper temperature before trays are assembled.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility improperly stored clean ice used for residents and staff food/fluid items near a sink utilized for handwashing and personal protective equipment (PPE) was not utilized correctly while providing wound care for Resident (R) 20. These deficient practices did not ensure a safe and sanitary environment and did not prevent the potential development and transmission of communicable disease and infections.Findings include: 1) On 04/28/26 at 06:05 AM, the supply room located across the nurses' station on the third-floor resident unit was checked with Registered Nurse (RN) 17 present. On the right side entering the room, was a counter with a microwave on the left side of the counter, paper towel dispenser and sink with no splashguards located in the middle section of the counter, and storage cabinet located on the right side of the counter. Next to the left edge of the sink was a small red storage cooler containing ice. RN17 stated it was clean ice stored for resident use. RN17 stated that the sink was used for both handwashing and to fill water for resident use. On the right side of the sink, various packaged food items were observed stored on top of a storage cabinet. Inside the storage cabinet were several fluid storage containers/bottles. RN17 stated that the food items were staff snacks and should not have been stored on the top of the storage cabinet. RN17 also stated that the storage cabinet was being used to store staff snacks and staff water bottles. On 04/28/26 at 12:45 PM observed Respiratory Therapist (RT) 19 and Certified Nurse Aide (CNA) 21 washing hands at the sink in the supply room on the third-floor resident unit and reaching towards the paper towel dispenser with wet hands with the red cooler containing ice in front of the dispenser. On 04/29/26 at 08:05 AM, observed RT4 washing hands using the supply room sink and reaching towards the paper towel dispenser with wet hands. The red cooler with the lid slightly raised from the ice stored in it remained placed in front of the paper towel dispenser. On 04/30/26 at 08:18 AM, observed CNA2 washing hands using the supply room sink and reaching towards the paper towel dispenser with wet hands. The red cooler with the lid slightly raised from the ice contained inside remained placed in front of the paper towel dispenser. On 04/30/26 at 11:06 AM, the DON was interviewed inside of the supply room. The DON confirmed that the sink was used both for handwashing and to fill water for resident use. The DON stated for infection control purposes the red cooler with ice and staff food/fluid should not be stored next to the sink. 2) On 04/29//26 at 10:00 AM, review of R20's electronic health record (EHR) noted that he has stage 4 pressure ulcer (PU) to his sacrum requiring daily wound care treatment and dressing change. On 04/29/26 at 12:30 PM, observed Registered Nurse (RN) 6 perform wound care to R20's PU. RN6 did not change gloves and perform hand hygiene after cleaning the sacral area with skin prep and prior to applying foam dressing. Concurrent interview with RN6 stated that she forgot to remove dirty gloves, do hand hygiene, and put on new gloves prior to applying the foam dressing. RN6 acknowledged the importance of changing gloves and hand hygiene to prevent spread of infection. On 04/30/26 at 02:50 PM, interview with Director of Nursing (DON) confirmed that RN6 should have changed gloves and perform hand hygiene prior to applying foam dressing to R20's PU. DON acknowledged that this is important for infection prevention. On 05/01/26 at 08:00 AM, review of the facility's Wound Management Policy with a reviewed/revised (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date of 03/31/26, stated, To promote wound healing of various types of wounds, it is the policy of this facility to provide.treatments in accordance with current standards of practice. Review of the facility's Hand Hygiene policy with a reviewed/revised date of 02/14/26, in the Policy Explanation and Compliance Guideline section, stated, 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation and interview, the facility failed to honor 1 of 1 resident's (Resident (R) 36) choice to eat lunch before doing therapy (physical and occupational). As a result of this deficient practice, R36's needs were not met and was placed at risk of not obtaining her highest practicable well-being.Findings include:On 04/28/26 at 12:15 PM, observed Certified Nurse Aide (CNA) 20 and CNA21 delivering meal trays to the resident rooms on the third floor. At 12:55 PM, observed physical therapy assistant (PTA) 1 finishing treatment to R36 and an uneaten lunch meal tray on R36's bedside table. At 01:00 PM, Respiratory Therapist (RT) 19, was suctioning R36 in preparation to deflate the tracheostomy cannula and attach the speaking valve to allow R36 to eat safely. However, R36 could not manage her secretions and catch her breath so lunch was held.On 04/30/26 at 12:44 PM, observed Certified Occupational Therapy Assistant (COTA) 1, providing treatment to R36 with the uneaten lunch meal tray situated on the resident's bedside table. COTA1 stated that there is no set schedule for therapy for the residents.On 04/30/26 at 10:17 AM, COTA1 was interviewed in the Rehab treatment area on the 4th floor with the Director of Rehab (DOR) present. COTA1 stated tries to avoid providing treatment during lunchtime unless eating is related to the treatment. COTA1 confirmed that eating was not part of R36's goals.On 04/30/26 at 10:55 AM, R36 was interviewed in her room with the DOR present. When asked about meal preference, R36's acknowledged preference is for Rehab therapy to come after lunch because therapy makes her tired and cough and is then too tired to eat.On 05/01/26 at 08:22 AM, the DON was interviewed in the conference room on the ground floor. The DON stated that nursing is not aware of the Rehab therapy's schedule, confirmed that the Rehab therapy is aware of the lunch period and should not be providing treatment during the meals, and stated discussion with therapy was needed to coordinate the schedules of residents receiving rehab therapy.

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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. Based on interview and record review, the facility failed to ensure that 2 of 5 residents (Resident (R) 32 and R35) sampled for unnecessary medications were free from chemical restraints. This was evidenced by no follow-up by the facility regarding the Consultant Pharmacist (CPH) 1's recommendation to provide a specific stop date/time period and a clinical rationale to continue an as needed (prn) psychotropic medication (Lorazepam) past 14 days for R32, no documentation of checking with the physician to taper the dose for an antipsychotic medication (Seroquel) that was ordered routinely for R32, no record of any side effects monitoring for psychoactive medication (Citalopram) ordered routinely for R35, and antipsychotic (Quetiapine) was ordered prn for greater than 14 days for R35. As a result of this deficient practice both residents were placed at risk of avoidable injury and/or a decline in their physical and psychosocial well-being.Findings include:1) On 04/29/26 at 04:12 PM, a record review for R32 was done and the following were found:A medication record review (MRR) for R32 done by CPH1 on 01/31/26 recommended providing a specific stop date or time period and a clinical rationale to continue the prn psychotropic (Lorazepam) past 14 days. No nursing progress note was found that the recommendation was followed up with R32's physician. R32's current order for Lorazepam 0.5mg every 6 hours prn order still listed a start date and revision date of 10/30/25. A MRR done by CPH1 on 03/31/26 documented to consider a taper (gradual dose reduction) for R32's order for Seroquel 12.5mg every bedtime. No nursing progress note was found that the recommendation was followed up with R32's physician and the current revision order date was listed at 12/01/25.2) On 04/29/26 at 04:21 PM, a record review for R35 was done and the following was found:A MRR done by CPH1 on both 12/31/25 and 03/31/26 recommended to record any side effects for R35's psychoactive medication order for Citalopram Hydrobromide 20mg via G-Tube one time a day. A review R36's current orders and April 2026 MAR did not list any monitor for side effects for this medication.R35 order for a prn antipsychotic (Quetiapine) prn was ordered on 04/02/26 and went over the 14-day time limit. No nursing progress notes or prescribing practitioner notes were found indicating R35 was directly examined and current condition assessed to determine if the prn antipsychotic was still needed.On 04/30/26 at 11:18 AM, the Director of Nursing (DON) was interviewed and a review of the MRR findings was done. The DON stated was made aware of the MRR process when moved into the role of the DON in February 2026 and was working on the process as the MRRs were not consistently being followed up on. A facility policy titled, Addressing Mediation Regimen Review Irregularities, with a date reviewed/revised date of 03/25/26, stated, 4. The pharmacist must report any irregularities to the attending physician, the facility's medical director, and director of nursing, and the reports must be acted upon.4. d. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it.9. Ongoing assessments will be conducted by nursing staff for identification of acute changes in a resident's condition that could possibly be medication-related.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident representative of resident's discharge/transfer for 1 of 3 residents (Resident (R) 12) and failed to notify the Ombudsman for 2 of 3 residents (R1 and R12) transferred to the hospital. As a result of this deficient practice, residents who are discharged /transferred from the facility are affected. Findings Include:1) On 04/28/26 at 01:57 PM, review of R1's electronic health record (EHR) noted that R1 was hospitalized on [DATE] for sepsis, and on 03/3/26 for gastrointestinal bleed with a hemoglobin level of 6.6, requiring blood transfusion.On 04/29/26 at 01:00 PM, a request was made to review the discharge/transfer notification to the family representative (FR) and Ombudsman for the two transfers to the hospital.On 04/30/26 at 02:00 pm, the Social Worker (SW) could not provide the discharge/transfer notification made to the Ombudsman. Concurrent interview with SW noted that he could not find any notifications made to the Ombudsman by the previous SW.2) On 04/29/26 at 8:50 AM, record review of R12's EHR noted that he was transferred to the hospital three times within the last 90 days. R12 was admitted to the hospital on [DATE] for pulmonary edema and pneumonia, on 02/13/26 for gastrointestinal bleeding, and on 02/26/26 for nausea and vomiting. On 04/29/26 at 01:00 PM, a request was made for the discharge/transfer notifications to the FR and Ombudsman for all three transfers to the hospital.On 04/30/26 at 02:00 PM, the SW could not provide the discharge/transfer notification for the 02/13/26 to the FR and was not able to provide any notification made to the Ombudsman. Concurrent interview with SW noted that they are still trying to find the 02/13/26 transfer notification to the FR and stated that he could not find any notification to the Ombudsman made by previous SW. On 04/30/26 at 03:30 PM, review of the facility's Transfer and Discharge (including AMA) policy, with a reviewed/revised date of 03/25/26, in the Policy Explanation and Compliance Guidelines section stated, 4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative.6.the notice must be provided to the resident, resident representative if appropriate, and LTC ombudsman as soon as practicable before the transfer or discharge. 7. The facility will maintain evidence that the notice was sent to the Ombudsman.

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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. Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan for 1 of 3 residents (Resident (R) 12) sampled for dialysis and 3 of 4 residents (R3, R6, R38) sampled for decreased mobility and range of motion (ROM).Findings Include:1) On 04/29/26 at 07:00 AM, observed R12 in bed and noted that a right upper arm fistula dressing was still on. R12 is on dialysis and had his dialysis treatment on 04/28/26. Concurrent interview with Registered Nurse (RN) 6 stated that R12 came back from dialysis around 09:30 PM on 04/28/26. When RN6 was asked about when do they remove the pressure dressing, RN6 noted that they are supposed remove it two hours after R12 comes back from dialysis, but they sometimes leave it on because of bleeding. On 04/29/26 at 08:00 AM, requested RN6 to see if there were any documentation of R12's fistula bleeding from the previous evening or night shift to warrant pressing dressing to be kept on, but no documentation could be found. RN6 acknowledged that the pressure dressing should have been removed to prevent R12's right upper arm fistula from occluding.On 04/29/26 at 09:00 AM, review of R12's care plan did not include any interventions to remove the pressure dressing within two hours of R12 return from dialysis. On 04/30/26 at 01:30 PM, interview with Director of Nursing (DON) confirmed that there should be an intervention to remove R12's pressure dressing within two hours of returning from dialysis to prevent access complications and occlusion. DON also stated that the care plan is the means to communicate and direct the resident's care and treatment. 2) On 04/28/26 at 09:53 AM, observed R3 asleep in bed with right hand contracture and no hand roll noted. Further observation throughout the day at 11:00 AM, 01:00 PM, and 02:30 PM noted no hand roll applied to R3's right hand contracture.On 04/29/26 at 09:00 AM, 11:00 AM, 01:00 PM, and 02:30 PM observed R3 with no hand roll applied to right hand contracture.On 04/29/26 at 10:00 AM, review of R3's care plan noted that she has limited physical mobility related to contractures, neurological deficit and weakness. Interventions noted to prevent contractures did not include application of hand roll to right hand. On 04/30/26 at 10:57 AM, interview with Certified Nurse Aide (CNA) 17 confirmed that they have not been applying anything to R3's right hand contracture. On 04/30/26 at 01:30 PM, interview with DON noted that the CNAs should have been applying the hand roll to R3's right hand and stated that R3 had a specific hand roll made for her. 3) On 04/29/26 at 10:00 AM, review of R3's care plan noted that she has limited physical mobility related to contractures, neurological deficit and weakness. Interventions noted to prevent contractures included providing gentle range of motion as tolerated with daily care. Review of R3's passive range of motion (PROM) to lower and upper extremities task documentation indicated that for majority of April, it was marked with Not Applicable.On 04/30/26 at 10:57 AM, interview with CNA17 confirmed that not applicable means that the task was not done. CNA17 further stated they have not been doing PROM with the residents' daily care as they do not have the time.On 04/30/26 at 01:30 PM, interview with the DON confirmed that the not applicable meant that the task was not done. DON acknowledged the importance of residents getting PROM with their daily care to prevent further contractures. 4) On 04/28/2026 at 11:46 AM, observed R38 laying on her back. Family member (FM) 1 stated that facility has not been doing any PROM and was told by R38's primary care provider (PCP) that the current physical therapy (PT) staff cannot do anything because R38 is not able to communicate.04/29/26 at 10:00 AM, review of R38's care plan noted that there was no PROM included in R38's mobility problem. Review of the R38's PROM to upper/lower extremities task documentation noted that for the majority of April, it was marked as not applicable.On 04/30/26 at 10:57 AM, interview with CNA17 confirmed that the not applicable meant that the task was not done. CNA17 further stated they have not been doing PROM with the residents' daily care as they do not have the time.On 04/30/26 at 01:30 PM, interview with the DON confirmed that the not applicable meant that the task was not done and acknowledged the importance of resident's getting PROM with their daily care to prevent further decline in their mobility (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and that PROM should have been included in R38's care plan despite R38's inability to communicate. 5) On 04/28/26 at 08:00 AM, interview with FM2 noted the facility stopped doing PROM with R6 about a year ago when the in-house physical therapy (PT) staff left. 04/29/26 at 10:00 AM, review of R6's care plan noted to provide gentle PROM with daily care. Review of the PROM to upper/lower extremities task documentation noted that for the majority of April, it was marked as not applicable.On 04/30/26 at 10:57 AM, interview with CNA17 confirmed that the not applicable meant that the task was not done. CNA17 further stated they have not been doing PROM with the residents' daily care as they do not have the time.On 04/30/26 at 01:30 PM, interview with the DON confirmed that the not applicable meant that the task was not done and acknowledged the importance of resident's getting PROM with their daily care to prevent further decline in their mobility.On 05/01/26 at 10:00 AM, review of the facility's Dialysis Treatment policy, with a reviewed/revised date of 03/19/26, in the Policy section, noted, This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician's orders, the comprehensive care plan. Review of the facility's Prevention of Decline in Range of Motion policy with a reviewed/revised date of 03/31/26, in the Policy Explanation and Compliance Guidelines, stated, Appropriate Care Planning, c. Care plan interventions will be developed and delivered through the facility's restorative program, or through specialized rehabilitative services as ordered by the attending practitioner.d. Interventions will be documented on the resident's person centered care plan.e. A nurse with responsibility for the resident will monitor for consistent implementation of the care plan interventions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to put in the care plan and implement individual activity preferences for 2 of 2 residents (Resident (R) 4 and R33) sampled. This deficient practice has the potential of not supporting the physical, mental, and psychosocial well-being of residents and not creating a meaningful life for residents residing in the facility.Findings include: 1) On 04/28/26 at 10:30 AM, observed R4 in bed watching television and when asked if he participated in any of the facility's activities, R4 noted that there are no activities being done that he was interested in. R4 verbalized that other than going to physical therapy, he has stayed in bed. On 04/28/26 at 01:00 PM, review of R4's Activities-Initial Review completed on admission on [DATE] noted that R4 prefers independent activities such as reading, watching TV, however, would like opportunities for outdoor strolls with wheelchair and porter assistance. On 04/29/26 at 1:00 PM, review of R4's Event Calendar Report for the month of March noted that R4 was invited but did not attend (marked on calendar as I) to go for an outdoor stroll on 03/14, 03/18, 03/21, 03/25, 03/28, and for the month of April, R33 was invited, but also did not attend outdoor strolls on 04/01, 04/04, 04/08, 04/11, 04/15, 04/18, 04/22, 04/25. On 04/29/26 at 01:30 PM, interview with Activities Coordinator (AC) confirmed that even if the residents were marked as invited on the calendar that it does not mean they completed or attended the activity. AC further stated that she was not currently doing outside strolls with residents as she is being pulled to do CNA duties. When asked about R4's outside stroll activities, AC noted that he was offered but declined invitation. When asked why R4 declined the invitation and where it would be documented, AC noted that she did not document refusals. On 04/30/26 at 09:00 AM, review of the facility's Activities policy with a reviewed/revised date of 03/18/26, in the Policy section, stated, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. 2) R33 is a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that include left basal ganglia intraparenchymal hemorrhage (bleeding stroke in the brain), ventilator associated pneumonia, and morbid obesity. On 04/28/26 at 02:40 PM, R33 was interviewed in his room. He was observed not connected to a ventilator and was able to nod his head to indicate yes or no. R33 was asked if he gets out of bed during the day for activities to which he nodded his head No. R33 nodded his head Yes when asked if there was an opportunity to go outside for fresh air, would he want to go outside. On 04/29/26 at 01:07 PM, the Activities Coordinator (AC) was interviewed in the ground floor conference room. The AC stated that all resident activities are provided one on one because it is difficult to coordinate and get cooperation from staff to get residents out of bed for activities. The AC also stated that although outdoor stroll is listed on the activities calendar that is given to the residents, it is currently not being done. On 04/30/26 at 04:30 PM, a review of R33's Minimum Data Set (MDS), with an Assessment Reference (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date (ARD) of 03/09/26, Section F0500: Interview for Activity Preferences, question G. (How important is it to you to go outside to get fresh air when the weather is good?) was coded as a 1 defined as very important. A review of R33's Activities care plan did not indicate this preference. A facility policy titled, Activities, with a date reviewed/revised of 03/18/26, stated, 2. Activities will be designed with the intent to: a. Enhance the resident's sense of well-being, belonging, and usefulness.i. Reflect choice of the resident.8. Activities will include individual, small, and large group activities as well as: a. Indoor and Outdoor activities.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 4 of 4 residents (Resident (R) 3, R6, R38, R44) sampled for limited range of motion (ROM) received the appropriate treatment, equipment, and services to maintain and/or prevent a decline in ROM and failed to ensure that a set facility procedure was in place to implement functional maintenance programs for residents as evidenced by no documentation that the functional maintenance program was performed for 1 of 1 resident (R44) sampled. As a result of this deficient practice, the residents were at risk of a decline in ROM and a loss of function.Findings include: 1) R44 is a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that include chronic respiratory failure with ventilator dependence and quadriplegia. On 04/28/26 at 11:30 AM, R44's Family Member (FM) 3 was interviewed in R44's room. FM3 stated visits daily from the morning until the evening. FM3 stated was informed by therapy that the certified nurse aides (CNA) should be doing ROM and the Activities Coordinator (AC) was trained but it does not occur. FM3 also expressed concern about other CNAs being trained on the specific exercises for R44 because it is not being done. On 04/30/26 at 09:57 AM the Director of Rehab (DOR) was interviewed. The DOR stated that anytime a resident is coming off therapy and will remain in the facility, Rehab will evaluate if a resident would benefit from a functional maintenance program which involves exercises and/or splint application. Training will be done by Rehab staff with facility staff and documented. The DOR also stated that therapy performed by Rehab and a functional maintenance program can overlap. On 04/30/26 at 11:30 AM, the DOR provided: Documentation of training with the AC and CNA20 for R44's functional maintenance program conducted on 02/04/26. Document listing details of R44's program: 2x/week, up to 30 mins for LE [lower extremity] as tolerated. 1x/week, up to 30 mins, for UE [upper extremity], as tolerated. LE Bilateral Hip and knee flexion/extension: 30 times each leg. UE: Shoulder Bilateral shoulder flexion/extension 30 times. L [left] shoulder: be aware of ventilator and tubes on L side. Document with pictorials and instructions for supine shoulder flexion passive range of motion (PROM) and supine hip and knee flexion PROM. On 05/01/26 at 08:28 AM, the Director of Nursing (DON) was interviewed in the conference room. The DON stated that there was no formal restorative program, but the AC is the staff member educated on resident functional maintenance programs and passes it on to other staff. The DON stated was unsure if documentation of training to other staff by the AC was being done, there was no set documentation to show that specific functional maintenance programs were being done for residents, and that a formal process needed to be set up to ensure facility staff are being educated and documentation completed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/26 at 08:30 AM, record review in the electronic health record (EHR) was completed. R44's functional maintenance program was not found in the care plan or physician orders and no documentation in the medication/treatment administration record or tasks documentation that the functional maintenance program was done. A facility policy titled, Prevention of Decline in Range of Motion, with a date reviewed/revised of 03/31/26, stated, 1. The facility in collaboration with the medical director, director of nurses, and as appropriate, physical/occupational consultants shall establish and utilize a systematic approach for prevention and decline in range of motion.3.b. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to: i. Appropriate services (specialized rehabilitation, restorative, maintenance).3. d. Interventions will be documented on the resident's person-centered care plan.4.c. Residents will receive services from restorative aides or therapists as needed. 2) R3 was admitted to the facility on [DATE] with a diagnosis of but not limited to chronic respiratory failure, cerebral infarction, limited mobility, neurological deficit and weakness, and right-hand contracture. On 04/28/26 at 09:53 AM, observed R3 asleep in bed with right hand contracture and no hand roll noted. Further observation throughout the day at 11:00 AM, 01:00 PM, and 02:30 PM noted no hand roll applied to R3's right hand contracture. On 04/29/2026, at 09:00 AM, 11:00 AM, 01:00 PM, and 02:30 PM observed R3 again with no hand roll applied to right hand contracture. On 04/30/26 at 10:57 AM, interview with Certified Nurse Aide (CNA) 17, confirmed that they have not been applying anything to R3's right hand contracture. On 04/30/26 at 01:30 PM, interview with DON noted that the CNAs should have been applying the hand roll to R3's right hand and stated that R3 had a specific hand roll at made for her. On 04/29/26 at 10:00 AM, review of R3's care plan noted included providing gentle range of motion as tolerated with daily care. Review of R3's passive range of motion (PROM) to lower and upper extremities task documentation indicated that for majority of April, it was marked with Not Applicable. On 04/30/26 at 10:57 AM, interview with CNA17, confirmed that the not applicable means that the task was not done. CNA1 further stated they have not been doing PROM with the residents' daily care as they do not have the time. On 04/30/26 at 01:30 PM, interview with the DON confirmed that the not applicable meant that the task was not done. DON acknowledged the importance of residents getting PROM with their daily care to prevent further contractures. 3) R6 was admitted to the facility on [DATE] with a diagnosis of but not limited to amyotrophic lateral sclerosis, functional quadriplegia, bilateral lower extremity contractures. On 04/28/26 08:00 AM, interview with family member (FM) 2 noted staff stopped doing PROM with R6 about a year ago when the in-house physical therapy (PT) staff left. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/29/26 at 10:00 AM, review of R6's care plan noted to provide gentle PROM with daily care. Review of the PROM to upper/lower extremities task documentation noted that for the majority of April, it was marked as not applicable. On 04/30/26 at 10:57 AM, interview with CNA17 confirmed that the not applicable means that the task was not done. CNA1 further stated they have not been doing PROM with the residents' daily care as they do not have the time. On 04/30/26 at 01:30 PM, interview with the DON confirmed that the not applicable meant that the task was not done. DON acknowledged the importance of residents getting PROM with their daily care to prevent further contractures. 4) R38 is a [AGE] year-old male, who was admitted to the facility on [DATE] with a diagnosis of chronic respiratory failure, cerebral infarction, and persistent vegetative state. On 04/28/26 at 11:45 AM observed resident laying on his back. FM1 stated that facility has not been doing any PROM and was told by R38's primary care provider (PCP) that the current physical therapy (PT) staff cannot do anything because R38 is not able communicate. 04/29/26 at 10:00 AM, review of R38's care plan noted that there was no PROM included in R38's mobility problem. Review of the PROM to upper/lower extremities task documentation noted that for the majority of April, it was marked as not applicable. On 04/30/26 at 10:57 AM, interview with CNA17, confirmed that the not applicable means that the task was not done. CNA17 further stated they have not been doing ROM with the residents' daily care as they do not have the time. On 04/30/26 at 01:30 PM, interview with the DON confirmed that the not applicable meant that the task was not done and acknowledged the importance of resident's getting PROM with their daily care to prevent further decline in their mobility and that PROM should despite R38's inability to communicate. On 05/01/26 at 10:00 AM review of the Prevention of Decline in Range of Motion policy with a reviewed/revised date of 03/31/26, in the Policy Explanation and Compliance Guidelines, stated, 1. The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventative care.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who require dialysis services are consistent with professional standards of practice. The facility failed to remove a pressure dressing after two hours from the completion of hemodialysis (HD) treatment for 1 of 3 residents (Resident (R) 12) sampled. This deficient practice puts residents on dialysis at risk for access clotting and complications.Findings Include: R12 is a [AGE] year-old male, who was admitted to the facility on [DATE] with a diagnosis of but not limited to acute respiratory failure, gastrointestinal hemorrhage, and end stage renal disease. R12 is on dialysis three times a week on a Tuesday, Thursday, Saturday schedule. On 04/29/26 at 07:00 AM, observed R12 in bed and noted that right upper arm fistula dressing was still on. R12 completed his dialysis treatment on 04/28/26. Concurrent interview with Registered Nurse (RN) 6 stated that R12 came back from dialysis around 09:30 PM on 04/28/26. The pressure dressing was left on for more than nine hours. When RN6 was asked when they remove the pressure dressing, RN6 noted that they are supposed to remove it after two hours from when R12 returned from dialysis, but sometimes the staff leave it on because of the access bleeding. On 04/29/26 at 08:00 AM, requested RN6 to see if there was any documentation R12's fistula bleeding from the previous evening or night shift to warrant pressing dressing to be kept on, but no documentation could be found. RN6 acknowledged that the pressure dressing should have been removed to prevent R12's right upper arm fistula from occluding.On 04/30/26 at 01:30 PM, interview with Director of Nursing (DON) confirmed that staff should have removed R12's pressure dressing after two hours of returning from dialysis as this is to prevent access complications and occlusion. On 05/01/26 at 10:00 AM review of the facility's Dialysis Treatment policy, with a reviewed/revised date of 03/19/26, in the Policy section, noted, This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician's orders, the comprehensive care plan. The Compliance Guidelines section stated, 9. The nurse will monitor and document the status of the resident's access site (s) to observe for bleeding, signs of infection or other complications.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F699 Trauma Informed CareBased on interview and record review, the facility failed to adequately assess for and identify past trauma experienced by 1 of 1 Resident (Resident (R) 8) sampled for Trauma-informed care (TIC). As a result of this deficient practice, R8 did not have his trauma triggers identified, placing him at increased risk of re-traumatization, and was hindered from attaining his highest practicable mental and psychosocial well-being.Findings include:R8 is a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that include depression, anxiety, insomnia and post-traumatic stress disorder.On 04/28/26 at 01:40 PM, R8 was interviewed in his room. When asked about past trauma in his life, R8 stated that he experienced trauma when he was a kid. R8 went on to state that his father used to be violent towards his mother and sisters and had nightmares about it in the past. R8 also stated that the Social Worker (SW) has not talked to him about his past trauma. On 04/30/26 at 12:10 PM, the Social Worker was interviewed in his office. The SW was asked if trauma screening was done on R8's most recent readmission [DATE]). The SW stated there was no specific trauma assessment/screening form that is utilized. The SW stated that a psychosocial assessment, which has one question about trauma, was completed on 03/16/26 for R8's readmission on [DATE]. The SW stated that it was completed late and should have been completed within the first 48 hours of admission. A concurrent review of the 03/16/26 psychosocial assessment was done and the answer to Section C. Current Mood and Status, Question 5. History of Trauma/PTSD was marked as NA (non-applicable). The SW stated that since starting in the position approximately 8 months ago, he was not aware of R8's PTSD diagnosis and no psychosocial assessment or trauma-informed care assessments completed prior to 03/16/26 were able to be found.On 05/01/26 at 09:07 AM, received the most recent facility training log for TIC and no completion date was found for the SW.A facility policy, titled, Trauma Informed Care with a date reviewed/revised of 04/01/26, stated, 2. The facility will use a multi-pronged approach to identifying a resident's history of trauma.This will include asking the resident about triggers that may be a stressor or may prompt recall of a previous traumatic event, as well as screening and assessment tools.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to review and act upon the pharmacist's recommendation on a monthly Medication Regimen Review (MRR) for 1 of 5 residents (Resident (R) 2) sampled. This deficient practice has the potential to negatively affect R2's overall health and well-being.Findings Include:On 04/30/26 at 01:00 PM, review of R2's MRR for 11/30/25 noted pharmacist recommendations to consider A1C (Hemoglobin A1c, a measure of glycated hemoglobin that reflects average blood sugar over the past two-three months) and CMP (comprehensive metabolic panel, a blood test that measures proteins and electrolytes levels), and the MRR for 03/30/26 also had recommendations to check A1c and CMP due to R2 receiving metformin, apixaban, and insulin. Review of R2's electronic health record (EHR) found no results of these blood tests.On 04/30/26 at 01:30 PM, interview with the Director on Nursing (DON) confirmed that there were no lab results and stated that the recommendations were not carried out. DON stated that he was only made aware of the MRR process recently and the recommendations for R2 were missed. DON acknowledged the importance of checking blood levels to ensure that medications are working and if changes need to be made.On 04/30/26 at 02:00 PM, review of the facility's Medication Regimen Review policy, with reviewed/revised date of 03/25/26, stated in the Policy Explanation and Compliance Guidelines section, e. For residents experiencing a change in condition.the facility will notify the pharmacy provider utilizing the Medication Regimen Review Communication form. The facility will complete the top portion of the form and provide the following information: nursing and/or physician documentation depicting the acute change, a copy of the current MAR, recent labs, and any other pertinent information.f. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125067	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Islands Skilled Nursing & Rehabilitation	1205 Alexander Street Honolulu, HI 96826

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 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, interview, and record review, the facility failed to ensure that medications and chemicals were stored in locked compartments on the third-floor resident unit. This deficient practice created a risk for inappropriate access and unsafe use by residents or unauthorized staff.Findings include:On 04/28/26 at 06:15 AM, the supply room located on the third-floor resident unit of the facility was checked. A box of individual bacitracin zinc ointment packets, a box of individual hydrocortisone packets, skin integrity wound cleanser, and liquid- loc plus medical fluid waste encapsulation and treatment bottles (used to convert liquid waste into a semi-solid gel) was observed in the unlocked storage cabinets located on the left side of the supply room as you enter.On 04/30/26 at 08:20 AM, observed unlocked medications stored on an open shelf left unattended with the office door open in the Director of Nursing's (DON) office located in the nurses' station on the third-floor resident unit. On 04/30/26 at 11:04 AM, the DON was interviewed in the third-floor resident unit supply room with concurrent observation of the supply cabinet. The DON confirmed that the box of individual bacitracin zinc ointment packets, a box of individual hydrocortisone packets, skin integrity wound cleanser, and liquid- loc plus medical fluid waste encapsulation and treatment bottles (used to convert liquid waste into a semi-solid gel) are medications and chemicals that should be in a locked storage. The DON also stated that the medication stored on the shelf in his office should also be locked.A facility policy titled, Medication Storage with a reviewed/revised date of 03/25/26 stated, 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms.