STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125070	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daniel K Akaka State Veterans Home	91-1204 Kealanani Ave Kapolei, HI 96707

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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 opened food was stored in accordance with professional standards for food safety for one of one observed walk-in refrigerator, placing residents at risk for foodborne illness. Specifically, a carton of heavy whipping cream and a large container of raw chicken were not properly stored.Findings Include: On 04/20/26 at 08:27 AM, during an initial kitchen tour with the Dietary Manager (DM), an open carton of heavy whipping cream was observed in the walk-in refrigerator that was not properly sealed or closed. The DM stated the heavy whipping cream is usually stored in another container.Further observation revealed a large container of raw chicken for chicken pot pie. More than half of the chicken was inside a covered bag; however, the remainder of the chicken was left uncovered and exposed to potential contamination. The DM confirmed the chicken should have been fully covered or stored inside the bag.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interviews, the facility failed to ensure that a resident was free from abuse for one of one resident (Resident (R) 7) reviewed for abuse. Specifically, R7 accused R82 of taking his belonging which resulted in R82 willfully striking R7.Findings Include: On 02/20/26, the facility submitted a completed event report to the State Agency (SA), Intake #2746056. The report documented that on 02/17/26 at 7:23 AM, R7 and R82 were in the dining area during breakfast. While R82 was ambulating to his table, R7 called R82 over. The residents began speaking, which escalated to both residents raising their voices and yelling. Staff responded and attempted to separate the residents. However, before staff could successfully intervene, R82 struck R7 on the forehead. R7 called law enforcement and R82 was taken into custody. Review of the facility's investigation report completed 02/18/26, concluded that the allegation of physical abuse was substantiated. The investigation further documented that R7 demonstrated a lack of trust toward others, exhibited accusatory behavior, and expressed concerns that other residents were taking his belongings. During staff interviews, a Certified Nursing Assistant (CNA) reported that prior to the incident, R7 stated he had observed R82 in the doorway of his room the night before. On 04/20/2026 at 11:40 AM, an interview was conducted with R7. R7 reported he had an altercation with another resident and called the police because the resident hit him, the resident was arrested for assault and battery. R7 stated he thought the resident stole his walker because it looked exactly like his and he saw that resident go by his room. R7 revealed a photo he took of himself, and the injury and bruising were observed near R7's eyebrow in the photo. R7 reported the injury was from the resident that hit him. On 04/23/26 at 10:39 AM, an interview was conducted with CNA4. CNA4 confirmed R7 was suspicious of R82 taking his belongings prior to the incident. CNA4 stated on 02/17/26, during breakfast at the dining room, R7 reportedly told CNA4 that R82 was going room to room and accusing R82 of taking things from his room. While helping R82 to the dining room table, R7 spoke with R82 and accused him of taking his walker. CNA4 stated he heard a loud noise and R82 yelling what did you say but did not know exactly what R7 said to R82. CNA4 did not see if R82 struck R7 but did see R82 flail his arms around. R7 had a red mark and bruise on his forehead after the incident. On 04/23/2026 at 12:36 PM, an interview was conducted with Resident Care Manager (RCM) 1. RCM1 confirmed R7 exhibits accusatory behavior and has history of accusing residents of stealing his belongings. RCM1 stated he was working the day the incident happened and was called to the unit. R7 accused R82 of stealing his walker and according to a witness R82 hit R7. R7's walker was found in his room and it was revealed that R82 was in possession of his own walker, not R7's. RCM1 confirmed staff should encourage R7 to report to staff members if he feels anything is missing to prevent him from confronting other residents due to his accusatory behavior and give the facility an opportunity to investigate. This was not expressed after the incident nor added as an intervention to the care plan. Review of the facility's policy and procedure Abuse, Neglect, and Exploitation (ANE) dated 10/20/25 documented to prevent all types of abuse the facility will identify, care plan, and implement appropriate interventions, and monitoring residents with behaviors and care needs that may increase their risk.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on resident interview, staff interview and record review, the facility did not update/revise the care plan for three Residents (R) 3, 7, 8 of nineteen residents reviewed. As a result of the deficient practice there was an increased risk of uncoordinated delivery of care. Findings Include: 1) During Resident interview on 04/20/26 at 09:30 AM, R3 said that he accidentally spilled hot liquid on himself on 04/03/26. Staff interview on 04/22/2026 at 10:20 AM, Staff Nurse 3 was aware of the incident, previously mentioned, and said since the incident they had implemented an intervention where only the kitchen would be allowed to heat up any liquids for the residents. On 04/22/2026 review of the comprehensive care plan for R3 did not include the intervention where only the kitchen would be allowed to heat up any liquids for the residents. Staff interview on 04/22/2026 at 10:25 AM, with Minimum Data Set (MDS) Nurse acknowledged that the comprehensive care plan was not updated to include the previous intervention and said they will make the necessary correction. 2) Resident interview on 04/21/2026 3:40 PM, R8 said the facility had restricted visitation from his spouse. Staff interview on 04/21/2026 at 3:45 PM, with Director of Social Services (SS) specified the reasons for restricting visitation for R8's spouse. On 04/21/2026 review of the comprehensive care plan for R8 showed the visitation restriction but also showed no restriction in another section. Staff interview on 04/21/26 at 3:50 PM, MDS Nurse acknowledged that the comprehensive care plan was not revised to remove the no restriction visitation. MDS Nurse said they would make the necessary revision. 3) Cross Reference to F600, Free from Abuse. The facility failed to ensure R7 was free from abuse. R7 accused R82 of taking his belonging which resulted in R82 willfully striking R7. On 04/23/26 review of the facility's investigation report completed 02/18/26, documented that R7 demonstrated a lack of trust toward others, exhibited accusatory behavior, and expressed concerns that other residents were taking his belongings. During staff interviews, a Certified Nursing Assistant (CNA) reported that prior to the incident, R7 stated he had observed R82 in the doorway of his room the night before. On 04/23/26 review of R7's comprehensive care plan documented R7 .lacks trust toward others and may exhibit accusatory behaviors toward others . The care plan described another incident on 10/03/25, Accusatory that someone took his watch from his overbed table. Watch was found on 10/6/2025 by water container outside near planters where he cares for the plants. Interventions include to Allow resident's name time to answer questions and to verbalize feelings perceptions, and fears and to Provide psychosocial well-being visit and provide support as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/26 at 10:39 AM, an interview was conducted with CNA4. CNA4 confirmed R7 was suspicious of R82 taking his belongings prior to the incident. CNA4 stated on 02/17/26, during breakfast at the dining room, R7 reportedly told him that R82 was going room to room and accusing R82 of taking things from his room. CNA4 did not intervene R7 from talking to R82 after previous knowledge of R7 expressing suspicion of R82. On 04/23/2026 at 12:36 PM, an interview was conducted with Resident Care Manager (RCM) 1. RCM1 confirmed R7 exhibits accusatory behavior and has history of accusing residents of stealing his belongings. RCM1 confirmed staff should encourage R7 to report to staff members if he feels anything is missing to prevent him from confronting other residents due to his accusatory behavior and give the facility an opportunity to investigate. This was not expressed after the incident nor added as an intervention to the care plan.

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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 the four resident unit lanai gate alarms were on. The deficient practice could affect all residents who are living on the first floor and are able to walk/wander on their own outside of the unit, putting them at risk for harm. Findings Include:On 04/20/2026 at 10:55 AM Resident (R) 47 was observed sitting in the unit dining room near the nurse's station. R47 was observed not wearing a wanderguard. A concurrent interview was conducted with Registered Nurse (RN)12 who was sitting at the nurse's station. Surveyor asked RN12 if R47 was wearing a wanderguard and RN12 confirmed resident was not wearing a wanderguard. On 04/20/2026 during a record review of the Facility Reported Incident (FRI) #2592877, that occurred on 08/17/2025, involving R47, found the facility had shared an initial report to the State Agency (SA), stating: At approximately 9:30 AM, RN noticed resident not seated at the dining room table. Facility Staff immediately searched property for resident. Resident was found walking towards the trash bin area. CNA asked resident where he was going and resident replied, I want to go home. CNA guided resident back to his nursing unit. RN completed head to toe assessment wit [sic.] no new skin impairments noted. No complaints of dizziness or headache. Vital signs were stable.The facility submitted a completed report to the SA, by email on 8/21/25 at 4:01 PM, which stated the following:Interview with DAY shift nurse: Nurse for Molokai unit noted that resident's name (R47) was last seen sitting at the dining table area around 9:10 AM. She went to care for another patient in a nearby room and when she came back to the dining area, she noticed resident's name (R47) was not sitting there anymore. Nurse checked his room and he was not in there, so she asked the facility staff to immediately search the property and a CNA found him walking outside towards the trash bin area. The CNA worked on Molokai unit and guided the resident back to the unit. Once resident's name (R47) returned to the unit, the nurse completed a full body assessment and found him to have no injuries, no complaint of dizziness or headache and his vital signs were stable. Continued completed report to the SA. Interviews with DAY shift CNAs: CNA1 had been assisting another CNA2 with a 2 person assist in a room when the RN on the unit called for the staff to search the property for resident's name (R47). CNA1 went out the back gate and found resident's name (R47) around the corner walking towards the trash bin area. CNA1 asked resident's name (R47), where are you going? and he replied, I want to go home. CNA1 said, Let me take you back to your room because your wife will be visiting soon and resident's name (R47) was happy to hear that. CNA2 said that she had seen resident's name (R47) at the dining area, which was a common spot he sits at. He either sits at the table or he stays in his room. She also noted that resident's name (R47) had been asking for his mom and for his home more often in the last week, but that he usually never walks around unless the nursing staff assist him. Continued completed report to the SA. Conclusion: After interviews with staff and upon medical record review, the elopement occurred possibly due to resident's name (R47) cognitive impairments. Resident's name (R47) had been stating he wanted to go home and had been asking for his mom on occasion that week, which may have led to his actions that day. Upon admission in May 2025, resident's name (R47) elopement risk assessment score was a 0 and he was deemed not to be an elopement risk. He had not exhibited any exit seeking behaviors prior to this occurrence, so a new elopement risk evaluation was completed right away, and his score changed and he was found to be at risk. resident's name (R47) was provided with a wander guard bracelet, his care plan was updated, the facility staff were educated on the change in his plan of care and he was provided with frequent checks to make sure he was safe and secure. Resident's name (R47) was also encouraged to attend activities. On 04/20/2026 record review of R47's Electronic Heath Record (EHR) found the resident had a risk assessment for elopement completed upon admission and after the elopement on 08/20/2025. The *NSG: Elopement Risk Evaluation - V2 from 08/20/2025 identified R47 as a high risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for elopement. On 04/21/2026 requested facility investigation for R47's elopement from Administrator which she was able to provide. Administrator shared the facility had installed alarms on the gates for all four units on the first floor. On 04/22/2026 at 08:15 AM interviewed Registered Nurse (RN)8 in person in the Bistro room. Inquired of RN8 about incident that occurred with R47 when he eloped from the facility on 08/17/25 and inquired where he was found. RN8 stated resident was found in the parking lot behind the building approximately 50 steps from the entrance. RN8 stated the door now has a very loud alarm on it so if someone opens it it will alarm. RN8 stated they put a WanderGuard on him (R47) afterwards. RN8 stated R47 was adjusting to the unit but wanted to go home because he missed his wife. RN8 stated during change of shift report she was notified that R47 had been seen packing his things and putting them by his door and stating he wanted to go home. RN8 explained R47 was out on the lanai and escaped from the Certified Nursing Assistant (CNA) who was attending to another resident. RN8 was looking for resident at this time and thought maybe he was in activities. RN8 assessed the resident after he was brought back onto the unit and he did not have any injuries he just stated he was tired from walking. RN8 stated she notified R47's wife of this incident. Surveyor asked RN8 if it is expected of the nurses to do a risk assessment for elopement if a resident is stating they want to go home and pack their belongings and RN8 confirmed it stating yes, it is expected of the nurse to do the risk assessment for elopement. RN8 stated if the resident is assessed as a high risk this is reported to the manager or supervisor on the weekend. RN8 stated they provide activities on the unit to distract the resident from eloping. Inquired if they put the WanderGuard on R47 and RN8 explained the maintenance department has to bring the WanderGuard to the unit to place on the resident. Inquired of RN8 who decides the resident would wear a WanderGuard and RN8 stated this would be decided by management with the doctor. On 04/22/2026 at 2:47 PM surveyor went around the facility first floor [NAME] and tested all the lanai gate alarms leading from the Molokai, Lanai, Maui and Kahoolawe units, leading out of the facility into the parking lot areas. 3 of 4 (Molokai, Lanai, and Kahoolawe) lanai gate alarms were off and the Maui lanai gate alarm was on. R47's unit lanai gate alarm was one that was off, Molokai.On 04/22/2026 at 3:07 PM met with and interviewed the Director of Maintenance and Plant Operations (DOMaPO) in the Bistro room, who was able to provide copies of when the lanai gates had their alarms tested. Inquired of DOMaPO if anyone else outside of the facility had access to the keys for the gate and he stated the landscapers have access to the key through a lock box and they came last week. Inquired about who did training with the landscapers regarding the keys, alarms and the alarms had to be turned on, and he stated he shared the information with one person at the landscaping company.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interview, and record review, the facility failed to ensure that one of two residents (Resident (R) 41) reviewed for oxygen (O2) services had a physician's order to receive oxygen therapy. The deficient practice placed the resident at risk of receiving unsafe or inappropriate oxygen therapy without proper medical authorization.Findings Include: On 04/20/2026 at 10:02 AM, R41 was observed in his room with O2 concentrator set at 3 litters via nasal cannula. The nasal cannula was not properly placed in the resident's nostrils and was positioned on his cheek. On 04/20/2026 at 10:04 AM, an interview was conducted with Registered Nurse (RN) 4. RN4 was informed that R41's nasal cannula was not properly placed. RN4 assisted with proper placement and stated that R41 is on continuous oxygen and on comfort measures. On 04/22/26 at 09:57 AM, R41 was observed sleeping in his room with an oxygen concentrator set at 2.5 liters via nasal cannula. On 04/22/26 during review of R41's Electronic Heath Record (EHR), no physician's order for oxygen therapy was found. On 04/22/26 at 09:58 AM, interview with RN6 was done. RN6 confirmed R41 was getting continuous oxygen through a nasal cannula due to chronic obstructive pulmonary disease (COPD) and during concurrent record review of R41's EHR with RN6 found no current physician's order for oxygen therapy. RN6 confirmed R41 should have an order for O2 for administration, including liter flow and method of administration. Review of the facility's policy and procedure Oxygen Administration dated 10/01/24, documented Oxygen is administered under orders of a physician .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to monitor behaviors related to an antidepressant medication prescribed for one of five residents (Resident (R) 12) reviewed for unnecessary medications. The deficient practice placed the resident at risk for adverse effects and inappropriate medication use. Findings Include: On 04/23/26 review of R12's Electronic Health Record (EHR) revealed R12 was prescribed 100 milligrams (mg) of bupropion HCl extended release daily for depression, effective 04/07/26. Behavior monitoring for the antidepressant was not initiated until 04/21/26. From 04/07/26 to 04/21/26, the facility did not document monitoring of R12's behavior related to bupropion use. On 04/23/26 at 12:35 PM, an interview was conducted with Resident Care Manager (RCM) 1. RCM1 confirmed that behavior monitoring should be initiated as soon as the antidepressant is ordered. Review of the facility's policy and procedure Medication Management dated 01/26, indicated After initiating or decreasing the dose of psychotropic medication, the behavioral symptoms must be reevaluated periodically to determine the effectiveness of the medication and the potential for reducing or discontinuing the dose.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on interview and record review, the facility failed to ensure one of one residents (Resident (R) 7) reviewed for rehabilitation services received speech therapy services to attain or restore the resident's highest practicable level of mental, functional, and psychosocial well-being, as the facility did not follow up with the physician to initiate services after a requested speech therapy evaluation to address decreased vocal volume.Findings Include: On 04/20/26 at 12:16 PM, an interview was conducted with R7. R7 stated he was supposed to receive speech therapy due to low vocal volume and had previously received services prior to admission to the facility. R7 further stated that nursing staff told him speech therapy is scheduled on Tuesdays and Thursdays, however, he attends dialysis on those days. R7 did not deny the therapy services, and no one spoke to him of any options to obtain the services. On 04/22/26 at 11:45 AM, an interview was conducted with the Director of Nursing (DON). The DON explained that when a resident requests therapy services, nursing staff submit a referral to the therapy department for assessment to determine eligibility. Nursing staff are then notified of the determination and obtain a physician's order if services are indicated. Review of R7's Electronic Health Record (EHR), revealed that on 09/17/25 a Nursing Communication For Therapy Screening was sent to the therapy department for speech therapy. On 09/17/2025, the Speech Therapist (ST) completed an assessment and determined R7 was a candidate for speech therapy, noting that resident reported he frequently loses his voice, has difficulty communicating his needs and becomes frustrated, and his vocal quality is harsh and breathy. On 04/23/26 at 12:11 PM, an interview was conducted with Speech Therapist (ST). ST confirmed she work at the facility on Tuesday and Thursday and will occasionally provide services on Monday and Friday. Inquired if there are set times she comes to the facility, ST stated it varies but will try to accommodate to the residents' schedules. If a resident is going to dialysis on Tuesday and Thursday, she will work with resident to accommodate a schedule. ST further explained that nursing staff makes a referral to therapy, they screen or assess the resident and based on the therapist's recommendation nursing staff will obtain an order from the physician. Concurrent review of communication between nursing and therapy, ST confirmed she assessed the resident and recommended R7 as a candidate for services on 09/17/25. On 04/23/26 at 01:54 PM, an interview was conducted with Resident Care Manager (RCM) 1. RCM1 stated there was no documentation indicating follow-up or action taken after the ST recommended speech therapy services for R7, and the services were not initiated.