STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 05/03/22 - 05/06/22. The facility was found not to be in substantial compliance with 42 CFR §483, Subpart B. Two complaints were investigated (ACTS #8995 and #9507). There were no deficient practices cited related to the complaint investigations. Survey Dates: 05/03/2022 - 05/06/2022 Survey Census: 84	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		6/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/03/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect and promote quality of life for two residents (Residents 45 and 11) in the sample by ensuring that they were treated with respect and dignity. Specifically, the facility failed to ensure staff provided feeding assistance in a manner that promoted independence and dignity, and failed to ensure catheter bag(s) (urine collection bag) were covered and not visible. As a result of this deficient practice, these residents had their dignity compromised and were placed at risk of a decreased quality of life. This deficient practice has the potential to affect all residents in the facility who receive assistance with feeding or have urinary catheters. Findings include:	F 550	F550 Resident Rights/Exercise of Rights Corrective Action R45 and R11 continue to reside at KPO. R45 care plan reviewed, and continues to require feeding assistance. AA1 was educated not to assist in feeding until competency completed. R11 catheter bag was placed in a dignity bag, covering it. Education initiated on 5/4/2022 to nursing staff on importance of ensuring that all residents with catheters bags have a dignity bag covering catheter bag at all times. Identification of Others	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 1) Resident (R)45 is 89-year-old male admitted to the facility on 12/12/21 with diagnoses that include non-traumatic brain dysfunction, high blood pressure, elevated lipids, depression, Alzheimer's disease, and chronic obstructive pulmonary disease (COPD). During a review of his Minimum Data Set (MDS) quarterly assessment with an assessment reference date (ARD) of 03/22/22, it was noted that R45 was evaluated as requiring one-person physical assistance with eating and had no functional limitation in range of motion in either of his upper extremities (shoulder, elbow, wrist, hand). On 05/03/22 at 12:20 PM, dining observations were done in the main dining room as tray pass began. Fourteen (14) residents (R) were observed in the dining room, all seated on different tables. On 05/03/22 at 12:43 PM, an observation was done of R45 as he received his tray. Activities Aide (AA)1 delivered R45's tray to his table and began prepping the tray by unwrapping/uncovering the food and drink items. At 12:45 PM, AA1 was observed beginning to feed R45 his lunch, using a regular utensil, as she stood over him on his right side. Several times throughout the next several minutes, R45 was observed attempting to reach for his lunch tray, food, his utensil(s), and/or his drinking cup. Each time, AA1 was observed either moving items out of his reach or moving his hand away from items he had reached for. At one point, as AA1 stepped away from the table to place a utensil that had fallen on the floor in the dirty bin, R45 picked up a regular spoon and began scooping food onto it. Before R45 could move the food-filled spoon to his mouth, AA1 returned	F 550	All residents who require assistance with feeding and have a catheter bag have the potential to be affected by this practice. Systemic Change All residents have the right to be treated with respect and dignity, and cared for in a manner that promotes independence. Staff Development coordinator or designee initiated staff education on 5/3/2022 promoting dignity. Monitoring Change The Director of Nursing and/or designee will audit 5 random staff per week x 4 weeks to ensure staff are promoting dignity, respect and independence during meals. The Director of Nursing and/or designee will audit five random residents who have a catheter bag to ensure a dignity bag is being used appropriately. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3	F 550		

to the table, grabbed the utensil from his hand, and resumed feeding him. At 12:50 PM, AA2 entered the dining room and relieved AA1 from assisting R45 with his meal. AA2 immediately pulled a chair over to the table and sat next to R45 as she allowed him to feed himself. R45 was observed successfully and without great difficulty, happily spooning food into his mouth. R45 was even observed attempting to feed AA2 some of his lunch, holding a spoonful of food up to her mouth.

On 05/03/22 at 12:53 PM, an interview was attempted with AA1 as she stood at the entrance to the dining room. AA1 was unable to respond appropriately to questions about feeding assistance. Although the questions were phrased in different ways by the Surveyor, based on her responses, AA1 did not understand what was being asked.

On 05/05/22 at 12:08 PM, an interview was done with the Staff Educator, who was also the Infection Preventionist (IP), in her office. The IP stated that Activity Aides are allowed to assist with nutrition/hydration under the supervision of a licensed staff. When asked about AA1 specifically, the IP confirmed that there is a bit of a language barrier. When the dining room observations were shared with the IP, she agreed whether familiar with the resident or not, everyone who assists with feeding should know to sit beside the resident, and to use techniques that promote independence, dignity, and the maintenance of functional abilities. Documentation of AA1's training and/or competency was requested at this time.

On 05/06/22 at 12:24 PM, the IP entered the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4	F 550		

conference room and reported that documentation regarding AA1's training and/or competency for assisting residents with feeding could not be located.

A review of the facility's policy and procedure on Feeding a Resident, last revised on 07/17/21, revealed the following:

"Policy...

This facility will ensure that:

Properly trained personnel supervised by nursing assist residents as needed with meals ... residents who are unable to feed themselves; and

Nursing personnel provide assistive devices to residents as directed by therapy and provide education to residents regarding the use of assistive devices.

Procedure ...

3. Sit to assist resident with eating ...

6. ...If possible, place utensil in resident's hand and guide from plate to mouth."

2) Resident (R)11 was admitted to the facility on 09/02/21 with diagnosis of unspecified quadriplegia and encounter for fitting and adjustment of urinary device.

Review of R11's quarterly Minimum Data Set (MDS) with an assessment reference date of 02/07/22, R11's Brief Interview Mental Status (BIMS) scored her at a 14 (cognitively intact).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5 On 05/03/22 at 08:29 AM observation and interview with R11 was done. Observed on the side of R11's bed, an uncovered catheter bag visible from outside of her room. R11's curtain was drawn and tied back. Inquired with R11 if she has a dignity bag that covers her catheter bag, R11 stated " ...once they put something on, I think it was when I went out to see a doctor ...I do not know where they keep it [dignity bag] ..." On 05/06/22 at 08:38 AM interview with Director of Nursing (DON) stated residents with a urinary catheter should have a dignity bag always covering their catheter bag.	F 550		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		6/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 6 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure Resident (R)49 participated in her comprehensive care plan meeting and (R)9's comprehensive care plan was revised to include recommendations from rehabilitation staff. Findings Include: 1) R49 was admitted to the facility on 10/01/14. Review of R49's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/22/22, R49's Brief Interview Mental Status (BIMS) scored her at a 15 (cognitively intact). On 05/04/22 at 10:01 AM interview with R49 was done. R49 stated she was not invited or participated in her care plan meeting. On 05/04/22 at 11:45 AM reviewed R49's Electronic Health Record (EHR). Review of R49's nursing note dated on 03/30/22 documented the care plan meeting was conducted with R49's representative. R49's EHR did not document R49's participation in the care plan meeting or document the reason R49 did not participate. On 05/06/22 at 08:10 AM interview with Unit Manager (UM)2 stated only residents without a representative attend their own care plan meeting. UM2 confirmed R49 did not attend her care plan meeting and document she informed	F 657	F657 Care Plan Timing and Revision Corrective Action R49 continues to reside at KPO and was invited on 3/24/2022 to the care conference scheduled on 3/30/2022. Executive Director initiated staff education on 5/25/2022 to invite and encourage resident's participation in care conferences. R9 was re-evaluated on 5/5/2022 by Occupational Therapy, and on 5/6/2022 by Physical Therapy. Resident was evaluated and picked up for Occupational Therapy to improve greater passive range of motion. Treatment plan is three times per week x 4 weeks. Physical therapy recommended passive range of motion by nursing staff 1-2x per day. Resident's care plan was reviewed and updated to include PT recommendations. Identification of Others All residents who are able to participate in their care conferences have the potential to be affected by this practice; Rehab and nursing leadership initiated audit on long term care residents to determine if all recommendations from therapy are care planned.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 7 R49 what was discussed. On 05/06/22 at 07:26 AM during an interview with Assistant Director of Nursing (ADON) inquired if residents, who are assessed cognitively intact, participate in their care plan meeting, ADON stated "for residents cognitively intact they should be there." Review of the facility's policy and procedures on "Resident Rights" last reviewed on 05/06/21 documents "The resident has the right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-center plan of care." Review of the facility's policy and procedures on "Comprehensive Care Plans and Revisions" with an issue date of 03/02/22 documents " ...each resident and resident representative, if applicable, is involved in developing the care plan making decisions about his or her care." 2) R9 was admitted to the facility on 12/18/19 with diagnoses of unspecified convulsions, functional quadriplegia, and muscle weakness. Review of R9's quarterly MDS with an ARD of 01/31/22, R9's cognitive skills for daily decision making was documented as severely impaired (never/rarely made decisions). Under Section G.Functional Status, R9's functional limitation in Range of Motion (ROM) for upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) documented impairments on both sides. R9 requires total dependence in bed mobility, dressing, eating, toilet use, and	F 657	Systemic Change All residents who are able to participate in their care conferences will continue to be invited and encourage their participation/physically attend to the extent practicable, to ensure a person centered plan of care. Staff will escort resident to the designated meeting area. Facility to continue rehab and nursing communication, with emphasis to ensure recommendations are care planned. Staff education, train-the trainer, to be completed related to passive range of motion for resident. Monitoring Change The Social Worker or designee will audit up to 5 random residents per week x 4 weeks to ensure resident was invited to care conference, encouraged to participate, and escorted to meeting area. The Director of Nursing and/or designee will audit 5 random residents x 4 weeks who have recommendations in the communication book to ensure recommendations are care planned. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 8 personal hygiene. On 05/05/22 at 01:28 PM interview with Restorative Nursing Aide (RNA)2 stated R9 does not have a restorative nursing program or a Passive Range of Motion (PROM)/ROM program. On 05/05/22 at 02:16 PM interview with Rehab Manager (RM) stated in the year 2020, nursing staff referred R9 to Physical Therapy (PT) to evaluate if R9 was appropriate for the RNA program. Concurrent review of the PT's evaluation and plan of treatment and PT's discharge summary both dated 05/02/20 documented R9 was not appropriate for the RNA program but recommended CNA staff to provide daily PROM to extremities using a pressure point release to relax R9's rigidity and tone and maintain his current range of motion. RM stated PT provided training to nursing staff utilizing the "Train the Trainer" plan. On 05/06/22 at 07:53 AM interview and concurrent review of R9's comprehensive care plan with Assistant Director of Nursing (ADON) was done. Inquired with ADON if PROM would be care planned if the PT made recommendations for the CNA's to provide R9 PROM through daily care and trained nursing staff, ADON stated it should be care planned. Concurrent review of R9's care plan, ADON confirmed R9's care plan was not person centered due to not including the PROM exercises recommended by PT.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the	F 676		6/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 9 resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide the proper care and treatment, including assistive devices, to	F 676	F676 Activities Daily Living/Maintain Abilities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 10 maintain the activities of daily living for two residents (Resident 45 and 19) in the sample. Despite identifying their feeding assistance needs, the facility failed to consistently implement the interventions necessary to maintain the residents' functional level and promote their independence. As a result of this deficient practice, the residents were placed at risk of not having their needs met and experiencing a decline in their physical well-being, psychosocial well-being, and quality of life. This deficient practice has the potential to affect all residents at the facility with feeding assistance needs. Findings include: 1) Resident (R)45 is an 89-year-old male admitted to the facility on 12/12/21 with diagnoses that include non-traumatic brain dysfunction, high blood pressure, elevated lipids, depression, Alzheimer's disease, and chronic obstructive pulmonary disease (COPD). During a review of his Minimum Data Set (MDS) quarterly assessment with an assessment reference date (ARD) of 03/22/22, it was noted that R45 was evaluated as requiring one-person physical assistance with eating and had no functional limitation in range of motion in either of his upper extremities (shoulder, elbow, wrist, hand). On 05/03/22 at 12:20 PM, dining observations were done in the main dining room as tray pass began. Fourteen (14) residents were observed in the dining room, all seated on different tables. On 05/03/22 at 12:43 PM, an observation was done of R45 as he received his tray. Activities Aide (AA)1 delivered R45's tray to his table and began prepping the tray by	F 676	Corrective Actions R45 and R19 continue to reside at KPO. R45 care plan reviewed, and continues to require feeding assistance. Staff, including AA1 was educated not to assist in feeding until competency completed. R19 care plan reviewed, and continues need for adaptive equipment during meals. UM was provided education on 5/3/2022. Effective 5/3/2022, dietary department started to include separate silverware on meal trays in the event that residents need assistance with feeding. Identification of Others All residents who require assistance with feeding or use adaptive equipment for meals have the potential to be affected by this practice. IDT reviewed list of residents with adaptive equipment for meals. Systemic Change All residents have the right to be treated with respect and dignity, and cared for in a manner that promotes independence. Staff Development coordinator or designee initiated staff education on 5/3/2022 promoting dignity. Dietary department started to include separate silverware on meal trays in the event that residents need assistance with feeding. Monitoring Change The Director of Nursing and/or designee will audit 5 random staff per week x 4 weeks to ensure staff are promoting dignity, respect and independence during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 11 unwrapping/uncovering the food and drink items. At 12:45 PM, AA1 was observed beginning to feed R45 his lunch, using a regular utensil, as she stood over him on his right side. Several times throughout the next several minutes, R45 was observed attempting to reach for his lunch tray, food, his utensil(s), and/or his drinking cup. Each time, AA1 was observed either moving items out of his reach or moving his hand away from items he had reached for. At one point, as AA1 stepped away from the table to place a utensil that had fallen on the floor in the dirty bin, R45 picked up a regular spoon and began scooping food onto it. Before R45 could move the food-filled spoon to his mouth, AA1 returned to the table, took the utensil from his hand, and resumed feeding him. At 12:50 PM, AA2 entered the dining room and relieved AA1 from assisting R45 with his meal. AA2 immediately pulled a chair over to the table and sat next to R45 as she allowed him to feed himself. R45 was observed successfully and without great difficulty, slowly spooning food into his mouth. On 05/03/22 at 12:53 PM, an interview was attempted with AA1 as she stood at the entrance to the dining room. AA1 was unable to respond appropriately to questions about feeding assistance. Although the questions were phrased in different ways by the Surveyor, based on her responses, AA1 did not understand what was being asked. On 05/04/22 at 04:20 PM, during a review of R45's comprehensive care plan, the following was noted as part of his care plan for activities of daily living: "Encourage ...[R45] to participate to the fullest extent possible with each interaction."	F 676	meals. The Director of Nursing and/or designee will audit up to 5 random residents x 4 weeks who use adaptive equipment during meals to ensure that an extra set of silverware are on meal trays, and that staff are not using residents' adaptive equipment to help feed resident. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 12	F 676		

On 05/05/22 at 12:08 PM, an interview was done with the Staff Educator, who was also the Infection Preventionist (IP), in her office. The IP stated that Activity Aides are allowed to assist with nutrition/hydration under the supervision of licensed staff. When asked about AA1 specifically, the IP confirmed that there is a bit of a language barrier. When the dining room observations were shared with the IP, she agreed whether familiar with the resident or not, everyone who assists with feeding should know to sit beside the resident, and to use techniques that promote independence, dignity, and the maintenance of functional abilities. Documentation of AA1's training and/or competency was requested at this time.

On 05/06/22 at 12:24 PM, the IP entered the conference room and reported that documentation regarding AA1's training and/or competency for assisting residents with feeding could not be located.

2) Resident (R)19 is an 83-year-old male admitted to the facility on 02/10/21 with diagnoses that include Type II diabetes, difficulty swallowing, dementia, history of stroke, anxiety disorder, pain in the right upper arm, and a history of falls. During a review of R19's care plan for Activities of Daily Living and Mobility, it was noted that R19 has "Limitation in ROM (range of motion) to right shoulder ...R19 requires extensive assistance by (1) staff to eat ...R19 requires nosey cup and built-up utensils to maximize independence with eating. Encourage R19 to utilize adaptive equipment with meals."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 13	F 676		

On 05/03/22 at 12:30 PM, R19 was observed in the dining room. R19's covered lunch tray was placed on his table but out of his reach.

On 05/03/22 at 12:33 PM, Unit Manager (UM)2 came over to assist R19 after she saw surveyor speaking to him. UM2 opened his lunch tray, retrieved a chair and sat next to him, and then used his special adaptive utensil (built-up spoon) to feed him spoonfuls of his pureed food without his assistance.

On 05/03/22 at 12:41 PM, R19 was observed being able to easily grab, hold, and lift cups with his left hand and drink from them without spilling or missing his mouth.

On 05/03/22 at 12:43 PM, R19 was observed grabbing his built-up spoon with his right hand, holding a pudding cup in his left hand, and feeding himself. R19 continued eating feeding himself without spilling any food or missing his mouth. R19's movements were sure and fluid with no hesitation, although very mild shaking was noted at times. R19 showed no expressions of pain or frustration.

On 05/03/22 at 12:57 PM, an interview with UM2 was done. UM2 stated that she gave R19 a choice of 2 spoons to use at the beginning of the meal, but he pushed them back to her, so that's why she "helped him eat." Surveyor did observe UM2 ask R19 which spoon he wanted to use but did not see him push both spoons towards her, refuse to feed himself, or complain of pain to his right shoulder, arm, or hand.

On 05/05/22 at 12:08 PM, an interview with Infection Preventionist (IP)/Staff educator, was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 14 done in her office. The IP agreed that UM2 should have allowed R19 to feed himself more. The IP stated that the Director of Nursing (DON) usually assists R19 with lunch and that the DON has "really been stressing independence." The IP stated that UM2 should be familiar with R19 but agreed that whether staff are familiar with a resident or not, independence should be promoted with all residents in order to maintain their activities of daily living. On 05/06/22 at 08:07 AM, Certified Nursing Assistant (CNA)1 was observed feeding R19 in his room. CNA1 used a spoon to feed R19 his breakfast while he sat in bed. CNA1 did not ask R19 if he wanted to use his built-up spoon to feed himself. On 05/06/22 at 08:19 AM, CNA1 was interviewed. CNA1 stated that she is new and is not assigned to R19 regularly. CNA1 stated that R19 does use a built-up spoon to feed himself but she forgot to offer it to him that morning. On 05/06/22 at 01:40 PM, a concurrent interview and record review of R19's care plan was done with the Assistant Director of Nursing (ADON). ADON confirmed that R19's care plan states that R19 should be encouraged to use his built-up utensils during meals to maximize his independence with eating. ADON confirmed that CNA1 should have offered and encouraged R19 to use his built-up spoon to feed himself during his breakfast meal that morning.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		6/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 15 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview with staff members the facility failed to recognize and assess risk factors regarding the cause of Resident (R)9's chapped lips to provide appropriate treatment. Findings Include: R9 was admitted to the facility on 12/18/19 with diagnoses of disturbances of salivary secretion, unspecified subsequent encounter allergy, functional quadriplegia, aphasia, constipation, dysphagia following nontraumatic intracerebral hemorrhage, gastrostomy status, colostomy status, unspecified disorder of the skin and subcutaneous tissues, and muscle weakness. Review of R9's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 01/31/22, R9's cognitive skills for daily decision making was documented as severely impaired (never/rarely made decisions). Under Section G.Functional Status, R9 requires total dependence in eating and personal hygiene. During multiple observations from 05/03/22 to 05/06/22, observed R9 to have large flaky skin around his mouth and his lips to be dry and cracked with thick peeling skin.	F 684	F684 Quality of Care Corrective Actions Staff applied over the counter chapstick on 5/5/2022 and ongoing. R9's care plan reviewed and updated on 5/26/2022 to include applying chapstick to resident's lips two times per day. Identification of Others All residents who require total dependence in eating and personal hygiene have the potential to be affected. Systemic Change All residents have the right to quality of care. Staff Development coordinator or designee initiated staff education on 5/5/2022 promoting a person centered plan of care. Monitoring Change The Director of Nursing and/or designee will audit up to 5 random residents per week x 4 weeks on residents who is dependent on feeding and personal hygiene, to ensure that lips are not dry, cracked, or peeling.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16 On 05/05/22 at 12:43 PM interview, concurrent review of R9's Electronic Health Record (EHR), and observation of R9 with Unit Manager (UM)2 was done. UM2 stated she was not aware of R9's lips being chapped. Review of R9's EHR, UM2 confirmed the EHR does not document possible risk factors and address R9's chapped lips. UM2 stated R9 has allergies but it does not specify dermatitis (skin inflammation). During concurrent observation of R9, UM2 confirmed R9's lips were chapped and stated it is a "possible sign of dehydration." UM2 could not confirm the cause of R9's chapped lips. On 05/06/22 at 08:00 AM interview and concurrent review of R9's EHR with Assistant Director of Nursing (ADON) stated a resident with dry chapped lips are a sign of dehydration and residents with tube feeding are at high risk of getting less fluids. ADON explained to determine if a resident were dehydrated nursing staff would check the resident's labs. Concurrent review of R9's EHR, ADON confirmed R9 does not have completed lab results to determine if R9 is dehydrated. ADON further stated R9 has sensitive skin and R9 may have a reaction to the lip balm being used. ADON could not confirm the cause of R9's chapped lips.	F 684	The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		6/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 17 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members the facility failed to ensure one of three residents (Resident (R)77) sampled received appropriate treatment and services to maintain and prevent further decrease in range of motion. Findings Include: Cross Reference to F725. The facility failed to provide sufficient staffing to ensure R77 received restorative nursing services as recommended by the rehabilitation therapist. R77 was admitted to the facility on 09/09/21 with diagnoses of unspecified quadriplegia, contracture right hip, contracture right knee, contracture unspecified knee, contracture left and right hand pain in right hand other muscle spasms, unspecified pain, sequela central cord syndrome at unspecified level of cervical spinal cord, and other symptoms and signs involving musculoskeletal system. Review of R77's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD)	F 688	F688 Increase/Prevent Decrease in ROM/Mobility Corrective Actions R77 continues to reside in the facility and continues to be on restorative nursing services. Identification of Others All residents who are in need of restorative nursing services have the potential to be affected by this practice. Systemic Change All nursing staff will be educated to provide range of motion during daily routine care to prevent decline in range of motion. During morning grand rounds, the interdisciplinary team discusses any decline in function and makes appropriate rehab referrals. Restorative Nursing Aide meeting frequency increased effective May 2022. Facility will continue to work on recruiting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 18 of 04/09/22, R77's Brief Interview Mental Status (BIMS) scored him at a 3 (severely impaired cognition). Under Section G.Functional Status, R77's functional limitation in Range of Motion (ROM) for upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) documented impairments on both sides. R77 requires total dependence in bed mobility, dressing, toilet use, and personal hygiene. On 05/04/22 at 3:16 PM review of R77's care plan last reviewed on 04/27/22 documents a nursing rehab/restorative program, providing Passive Range of Motion (PROM). On 05/05/22 at 09:33 AM review of R77's nursing note dated 03/30/22 documents "Order for PT [Physical Therapy] referral received to assess resident to verify if knee brace is still beneficial due to being very stiff." On 05/05/22 at 01:17 PM interview and concurrent review of R77's Electronic Health Record (EHR) was done with Restorative Nursing Aide (RNA)2. RNA2 confirmed R77 is a part of the RNA program and recently received PT and Occupational Therapy (OT) services due to a decline in Range of Motion (ROM). RNA2 stated if a resident receives PT and OT the RNAs continue to provide their services but not as frequently as two to three times per week. Concurrent review of R77's EHR documents RNA services were provided twice (04/28/22 and 05/04/22) from 04/05/22 to 05/05/22. Inquired with RNA2 what "not applicable" means in the remaining 30 days services were not provided, RNA2 stated " ...not able to provide the service because busy." RNA2 was unable to retrieve documentation past 30 days in the EHR.	F 688	and retaining certified nurse aides; work with CNA School of Hawaii for KPO to become a clinical site; assess facility patient acuity to determine appropriate staffing measures; continue to offer bonuses and free meals for staff. Monitoring Change The Director of Nursing and/or designee to audit 5 staff members per week x 4 weeks to ensure they are comfortable with providing Range of Motion as they are rendering patient care. The Executive Director and/or designee to log number of applicants, interviews, and onboarding/new hires, weekly x 4 weeks. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 19 On 05/05/22 at 02:04 PM interview with Rehab Manager (RM) and concurrent review of R77's EHR was done. RM stated R77 was referred to PT on 03/28/22 and evaluated on 03/30/22. RM explained R77 had a knee brace, and it was not fitting properly, " ...I believe they [nursing staff] were worried due to decrease of range of motion." Inquired possible reasons R77 may have a decrease in ROM, RM stated not receiving PROM or ROM stretching, " ...less stretching in positioning it can be harder and harder to stretch out." On 05/06/22 at 07:30 AM interview with Assistant Director of Nursing (ADON) stated R77 was referred to therapy because R77 " ...has a brace in his right knee and is very contracted ....we noticed he had pain his knee, putting a brace on would be difficult ...He is quadriplegic because of his diagnosis ...he is not able to move so we pretty much do everything ..." for him including stretching. Concurrent review of R77's EHR documents RNA services were provided twice (04/28/22 and 05/04/22) from 04/05/22 to 05/05/22. ADON was unable to retrieve documentation past 30 days in the EHR. Requested ADON to provide three months of documentation of PROM services prior to the referral to PT, on 03/28/22. At 12:45 PM ADON provided documentation of PROM services provided to R77 from 02/27/22 to 03/30/22, one month prior to referral to PT. Concurrent review with ADON, ADON confirmed R77 did not receive services consistently every week.	F 688		
F 698 SS=E	Dialysis CFR(s): 483.25(l)	F 698		6/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 20 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to document information completely and accurately on the Pre/post dialysis communication page for two of two residents (R)85 and R58 sampled. The deficient practice has the potential to increase the risk of an adverse event during or after the resident's hemodialysis treatment for all residents who receive hemodialysis. Findings include: 1) On 05/04/22 at 03:34 PM, a concurrent interview and review of R58's Pre/Post Dialysis Communication records was done with Registered Nurse (RN) 7. RN7 confirmed there was information missing from R58's Pre/Post Dialysis Communication records for 04/15/22, 04/27/22, and 04/29/22. On the Pre/Post Dialysis Communication page for entry dated 04/15/22, there was no condition of access/site documented by the facility staff in the Pre-Dialysis section. In addition, there was no contact person, or condition of access/site, or post-dialysis weight documented by dialysis staff in the Dialysis Center Section of the form. On the Pre/Post Dialysis Communication page for entries dated 04/15/22 and 04/27/22, there were no vital signs (temperature, pulse, respirations, and blood pressure), weight, condition of access/site, bruit present, thrill present, change of site,	F 698	F698 Dialysis Corrective Actions R85 was discharged from the facility on 3/29/2022. R58 continues to reside at KPO. DON initiated education to license staff on 5/4/2022 to emphasize the importance of completing Pre/Post Dialysis communication. Identification of Others All residents who receive hemodialysis treatments have the potential to be affected. Systemic Change All residents who receive hemodialysis will have a Pre/Post Dialysis communication record to avert the risk of an adverse event during or after the resident's treatments. Unit manager daily task added to check for completion of Pre/post dialysis communication record on a daily basis. Monitoring Change The Director of Nursing and/or designee will audit up to 5 random residents per week x 4 weeks for completion of pre/post dialysis communication record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 21 signature/title, date and time documented by the facility staff in the Post Dialysis section. On the Pre/Post Dialysis Communication page dated 04/29/22, there was no condition of access/site, weight in pounds, and whether a meal was given to the resident to take to the dialysis center documented by facility staff in the Pre-Dialysis section; no contact person and condition of access/site documented by dialysis staff in the Dialysis Center section; and no vital signs (temperature, pulse, respirations, and blood pressure), condition of access/site, bruit present, thrill present, change of site, signature/title, date and time documented by the facility staff for the Post Dialysis section. RN7 stated that the nursing staff are responsible for ensuring that the Pre/Post Dialysis communication form is completed entirely for every dialysis session that R58 attends. (Cross reference to F842 medical records). On 05/04/22 at 03:58 PM, a concurrent interview and review of R58's Pre/Post Dialysis Communication records was done with the Director of Nursing (DON). DON confirmed that information was missing from R58's Pre/Post Dialysis Communication Records for 04/15/22, 04/27/22, and 04/29/22. DON stated the nursing staff are responsible for completing R58's Pre/Post Dialysis Communication form before and after each of R58's dialysis sessions. DON stated that the nursing staff are also responsible for ensuring that the Dialysis Center section of the Pre/Post Dialysis Communication form is also completed by R58's dialysis center. 2) On 05/05/22 at 08:11 AM the medical record for R85 was reviewed. Surveyor noted there was information missing from the pre/post dialysis	F 698	The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 22 communication records on 03/23/22, 03/25/22 and 03/28/22. On the Pre/post dialysis communication page dated 03/23/22, there was no signature/ title or date/time completed by the staff at the dialysis center (the middle section on on the page). There was no weight documented in the post dialysis section of the form or condition of access or change of site documented by the facility staff on the bottom of the form. On the Pre/post dialysis communication page dated 03/25/22, the dialysis center section was missing dialysis center name, nephrologist, telephone, contact person and temperature. The post dialysis section was blank, and the vital signs were crossed out with no note to indicate why. The Pre/post dialysis communication form dated 03/28/22 in the Pre-Dialysis section had vital signs documented and the rest of the assessment section was blank. The dialysis center section was missing the staff signature, date, and time, (cross reference to F842 medical records). Surveyor reviewed the Dialysis policy, effective date 04/24/19, Rev: 12.29.21. "Purpose: To provide care guidelines for the resident who receives dialysis at another facility. This facility assures that each resident receives care and services for the provision of hemodialysis and or peritoneal dialysis consistent with professional standards of practice...3. Initiate the Pre/post dialysis communication form to be sent to the dialysis clinic with the resident. Post-Dialysis: 1. Obtain vital signs of resident upon return from dialysis and complete the Pre/post dialysis communication form.	F 698		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		6/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 23 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members the facility failed to provide sufficient staffing to ensure Resident (R)77 received restorative nursing services as recommended by the rehabilitation therapist. Findings Include: Cross reference to F688. The facility failed to	F 725	F725 Sufficient Nursing Staff Corrective Actions R77 continues to reside in the facility and continues to be on restorative nursing services. Identification of Others All residents who are in need of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 24 ensure R77 received appropriate treatment and services to maintain and prevent further decrease in range of motion. On 05/05/22 at 11:10 AM interview with Restorative Nurse Aide (RNA)1 was done. RNA1 stated she has not been implementing residents' restorative nursing programs regularly and consistently because the Certified Nursing Aides (CNA) need help on the floor. RNA1 explained due to staff shortage and staff calling in sick she is pulled from providing RNA services and is asked to cover as a CNA. Review of R77's "Restorative Nursing Communication Tool" dated 03/10/22 and 04/26/22, documented R77 should have received Upper Extremity (UE) Passive Range of Motion (PROM) twice a week for 10 minutes per day and Lower Extremity (LE) PROM three times a week for 15 to 20 minutes per day. On 05/05/22 at 01:17 PM interview with RNA2 was done. RNA2 confirmed R77 has a restorative nursing program. RNA2 stated a referral to rehabilitation therapy was made for R77 because of a decline in R77's range of motion and expressing pain when stretched. RNA2 stated due to staff calling out sick, "sometimes RNA services cannot be done because they have to be on the floor." RNA2 explained part of her responsibilities besides implementing the restorative nursing programs are to help the CNAs, help with admissions, and weigh the residents on Monday and Tuesday. Concurrent review of R77's Electronic Health Record (EHR) noted that it documents restorative services provided on 04/28/22 and 05/4/22 for 15 minutes in the last 30 days. Inquired with RNA2	F 725	restorative nursing services have the potential to be affected by this practice. Systemic Change All nursing staff will be educated to provide range of motion during daily routine care to prevent decline in range of motion. During morning grand rounds, the interdisciplinary team discusses any decline in function and makes appropriate rehab referrals. Restorative Nursing Aide meeting frequency increased effective May 2022. Facility will continue to work on recruiting and retaining certified nurse aides; work with CNA School of Hawaii for KPO to become a clinical site; assess facility patient acuity to determine appropriate staffing measures; continue to offer bonuses and free meals for staff. Monitoring Change The Director of Nursing and/or designee to audit 5 staff members per week x 4 weeks to ensure they are comfortable with providing Range of Motion as they are rendering patient care. The Executive Director and/or designee to log number of applicants, interviews, and onboarding/new hires, weekly x 4 weeks. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 25 the charted "not applicable" for remainder 28 days, RNA2 stated "not applicable" means they were unable to provide services because they were busy. On 05/06/22 at 07:30 AM interview with Assistant Director of Nursing (ADON) was done. ADON stated residents in the restorative nursing program usually receive services two to three times per week depending on what was recommended by the therapists but currently have been getting services one to two times a week. ADON confirmed RNAs are getting pulled to the floor as a CNA due to staff members calling out sick for work. ADON stated "that is the problem, they [residents] don't get their program ..."	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758		6/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 26 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor the medication regimen for one resident (R) in the sample and ensure that she did not have any "PRN [as needed]" orders for psychotropic drugs (any drug that affects brain activities associated with mental processes and behavior) for longer than fourteen days. As a result of this deficient practice, Resident (R)55 did not have her medication regimen effectively	F 758	F758 Unnecessary Psychotropic Meds Corrective Action R55 no longer resides in facility. R55 medication review completed by Director of Nursing on 5/6/2022. R55's doctor updated and discontinued order on 5/6/2022. Doctor reinstated Trazadone on 5/11/2022 with a discontinue date of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 27 monitored, placing her at risk for adverse effects related to unnecessary medication. This deficient practice has the potential to affect all the residents at the facility taking psychotropic medications. Findings include: Resident (R)55 is a 90-year-old female admitted to the facility on 03/31/22 for rehabilitation following surgery on her back. During a review of her electronic health record (EHR) on 05/04/22 at 09:15 AM, the following "PRN [as needed]" order for a psychotropic medication was noted from 04/07/22: "trazodone HCl [hydrochloride] Tablet Give 25 mg [milligrams] by mouth as needed for Sleep ..." The order had no end date. A review of R55's progress notes revealed no documentation questioning or justifying the extension of the PRN Trazodone order past fourteen (14) days. On 05/06/22 at 10:38 AM, an interview was done with the Director of Nursing (DON) in her office. When asked, the DON stated the last Psychotropic Review Team Meeting was held on 04/27/22 but that the Team only reviews the psychotropic medications for residents on the long-term care side. When asked specifically about R55's PRN Trazodone order, the DON stated that the Unit Managers on the rehabilitation side of the facility should know to ensure PRN psychotropic medication orders are put in for a maximum of 14 days. The DON reviewed R55's orders and confirmed that the PRN Trazodone order had been missed. The DON stated that the order should have an end date, and/or a	F 758	5/25/2022. Identification of Others All residents who receive PRN psychotropic medication have the potential to be affected. Systemic Change All residents who receive PRN psychotropic medication will have their medication regimen effectively monitored to avert adverse effects related to unnecessary medication. Staff will be educated on regulation regarding PRN psychotropic drugs. Monitoring Change The Director of Nursing and/or designee will audit up to 5 random residents per week x 4 weeks to ensure there is a discontinue date on PRN psychoactive medications. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 28 justification for extending it past 14 days.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all medications used in the facility were securely stored in locked compartments, and failed to dispose of expired spacers for three Residents (R) (Resident 80, 46, and 60) sampled. Proper storage and labeling of medications is necessary to promote safe	F 761	F761 Label/Store Drugs and Biological Corrective Action All expired spacers were discarded on 5/5/2022; all 3 residents identified had unexpired spacers already in medication cart.	6/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 29 administration practices, and to decrease the risk of medication errors and diversion of resident medications. This deficient practice has the potential to affect all residents in the facility. Findings include: 1) On 05/03/22 at 11:35 AM, observed an unlocked and unattended medication cart outside room 406. Approximately two minutes later, observed Registered Nurse (RN)5 walk to the cart from the Nurses' Station. When asked about the unlocked medication cart, RN5 stated he normally locks it but was busy discharging a resident, so he forgot. 2) On 05/04/22 at 03:00 PM, observed both medication carts between 506 and 508 were left unlocked and unattended with the laptop screens on the medication carts displaying resident information. Unit Manager (UM)1 exited a room near the carts and walked past both medication carts without locking them or closing the laptop screens. Surveyor called UM1 back to the medication carts but before she arrived, RN6 walked up to one of the carts and moved his hand to lock it. Surveyor asked RN6 to leave everything as it was until UM1 returned. RN6 admitted that he left one of the carts unlocked, explaining that he had a resident that was in a lot of pain, so he was distracted and forgot to lock the cart. UM1 locked the second cart. On 05/04/22 at 03:07 PM, observed RN6 walk away from his medication cart, leaving it unlocked as he entered a resident's room. UM1 was notified and she called RN6 to secure his cart. On 05/04/22 at 03:11 PM, observed RN3 remove	F 761	R46, R60, and R80 continue to have active orders for inhaler. Facility wide audit of medication carts completed. Expired spacers were removed from med carts on 5/5/2022. Staff education initiated on 5/4/2022 to emphasize importance of locking medication carts when left unattended. Identification of Others All residents who reside in the facility have the potential to be affected by this practice. Systemic Change All license staff education initiated on 5/4/2022 to ensure medication carts are locked when left unattended; and checking expiration dates for all medications, miscellaneous supplies (i.e. spacers). Monitoring Change The Director of Nursing and/or designee will audit up to 5 medication carts per week x 4 weeks to ensure it is locked when unattended, and that miscellaneous supplies (i.e. spacers) are not expired. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 30	F 761		

medication from the medication cart outside of room 506, and walk away from it, leaving it unlocked, as she entered a resident's room. UM1 was notified.

3) On 05/03/22 at 12:31 PM observed an unlocked and unattended medication cart in the hallway next to the Nurse's station. At 12:32 PM Registered Nurse (RN)7 approached the medication cart and returned to a resident's room without locking the medication cart. Staff members were observed to walk past the unlocked medication cart as they were passing lunch trays to residents in their rooms. At 12:40 PM observed RN7 run to the unlocked medication cart. RN7 confirmed the medication cart was unlocked and stated, "I just saw it and my heart skipped a bit."

4) On 05/05/22 at 09:15 AM, surveyor observed 3 expired spacers (a tube connected to a respiratory inhaler medication and then placed in resident's mouth to help assist in the administration of medication) in Cart 200. The three expired spacers were:

1. Resident (R) 60. Aerochamber Plus Flow-Vu. Use with inhaler every 4 hours PRN (as needed) shortness of breath. Opened 04/01/20. Discard after 02/21.
2. Resident (R) 46. Aerochamber Plus Flow-Vu. Use with inhaler every 4 hours PRN (as needed) shortness of breath. Opened 03/32/20. Discard after 02/21.
3. Resident (R) 80. Aerochamber Plus Flow-Vu. 1 unit miscellaneous every 4 hours as needed for us of albuterol inhaler. No opened date written. Discard after 12/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 31	F 761		

On 05/05/22 at 09:15 AM, a concurrent observation and interview was conducted with Registered Nurse (RN) 8. RN8 observed and confirmed that the spacers for R80, R46, and R60 were expired and should have been discarded. RN8 stated that all staff that have access to a medication cart should be checking its contents for expiration dates once a shift.

On 05/05/22 at 10:06 AM, the Director of Nursing (DON) was interviewed. DON stated that all staff that have access to the facility's medication carts should check its contents for expiration dates. DON confirmed that the spacers were expired and should have been discarded.

On 05/06/22 at 09:23 AM, a concurrent interview and record review was done with the Assistant of Director of Nursing (ADON) . ADON stated that the facility does medication cart audits with multiple nurses and stated, "I guess some of us didn't know there was an expiration date for the spacers." ADON stated that the Aerochamber Plus Flow-Vu is used to administer albuterol (respiratory) medication. ADON confirmed that R60, R46, and R80 are diagnosed with chronic obstructive pulmonary disease (respiratory disease that causes persistent respiratory symptoms such as breathlessness and cough) and that albuterol might be ordered depending on the physician. ADON confirmed that R60's spacer should have been discarded and replaced when it expired on 02/21 because R60 had an order for albuterol PRN (as needed) that was active until it was discontinued on 03/30/21. ADON also confirmed that R46 has a current order started on 01/26/22 for "Albuterol Sulfate HFA Aerosol Solution 108 (90 Base) MCG/ACT. 2 puff inhale orally every 4 hours as needed for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 32 shortness of breath. Use with spacer" and that her current spacer (expired 2/21) needs to be replaced. ADON also confirmed that R80 has a current order started 04/27/22 for "Albuterol Sulfate HFA Aerosol Solution 108 (90 Base) MCG/ACT. 2 puff inhale orally every 4 hours as needed for shortness of breath, wheezing; use Spacer," and that R80's current spacer (expired 12/21) needs to be replaced. On 05/06/22 at 10:30 AM, a review of the facility's policy "Medication Storage, Section 4.1 Storage of Medication" dated 01/21 states, "14. Outdated, contaminated, discontinued or deteriorated medications and those in container that are cracked, soiled, or without secure closures are immediately remove from stock, disposed of ...and reordered from the pharmacy if a current order exists."	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		6/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 33 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, the facility failed to label and date a container storing food thickener in the facility's kitchen. This deficiency has the potential to affect facility residents requiring food thickener in their diets by putting them at risk for possible foodborne illness caused by unlabeled and undated food products. Findings include: On 05/03/22 at 08:09 AM, a concurrent observation and interview was done with the Food Service Manager (FSM) in the facility kitchen. A clear, covered container filled with a white powdered substance with no label or expiration date was observed in the kitchen area. FSM confirmed that Thick-it (food thickener) was in the container and was just filled that morning . FSM confirmed that the container should be labeled with an expiration date and the contents of the container. On 05/06/22 at 08:00 AM, a review of facility policy "Use by Dates - Nursing/Activities Pantry Items" dated 12/15/2009 states, "All food items out of their original container need to be labeled with name of item and Use-By-Date ...Use By Date: Thickener: 6 months open."	F 812	F812 Food Procurement, Store, Prepare/Serve-Sanitary Corrective Action Thick-it container was properly labeled with contents and a Use by Date on 5/3/2022. Identification of Others All residents who require food thickener have the potential to be affected by this practice. Systemic Change Dietary staff education initiated on 5/3/2022 –Staff will label the container lid prior to refilling the container with thick it. Monitoring Change The Food Service Manager or designee will randomly audit, containers, specifically thick-it, at least 3x per week x 4 weeks, to ensure use by date, and contents label are on lid. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		6/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 34	F 842		

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 35 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to completely document pertinent information on the Pre/Post dialysis communication page in two residents (R)85 and R58 in the sample. The deficient practice has the potential to increase the resident's risk of an adverse event during a hemodialysis treatment for all residents on hemodialysis. Findings include:	F 842	F842 Resident Records – Identifiable Information Corrective Actions R85 was discharged from the facility on 3/29/2022. R58 continues to reside at KPO. DON initiated education to license staff on 5/4/2022 to emphasize the importance of completing Pre/Post Dialysis communication.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 36 (Cross reference to F698 Dialysis) 1) On 05/04/22 at 03:34 PM, a concurrent interview and review of R58's Pre/Post Dialysis Communication records was done with Registered Nurse (RN) 7. RN7 confirmed there was information missing from R58's Pre/Post Dialysis Communication records for 04/15/22, 04/27/22, and 04/29/22. On the Pre/Post Dialysis Communication page for entry dated 04/15/22, there was no condition of access/site documented by the facility staff in the Pre-Dialysis section. In addition, there was no contact person, or condition of access/site, or post-dialysis weight documented by dialysis staff in the Dialysis Center Section of the form. On the Pre/Post Dialysis Communication page for entries dated 04/15/22 and 04/27/22, there were no vital signs (temperature, pulse, respirations, and blood pressure), weight, condition of access/site, bruit present, thrill present, change of site, signature/title, date and time documented by the facility staff in the Post Dialysis section. On the Pre/Post Dialysis Communication page dated 04/29/22, there was no condition of access/site, weight in pounds, and whether a meal was given to the resident to take to the dialysis center documented by facility staff in the Pre-Dialysis section; no contact person and condition of access/site documented by dialysis staff in the Dialysis Center section; and no vital signs (temperature, pulse, respirations, and blood pressure), condition of access/site, bruit present, thrill present, change of site, signature/title, date and time documented by the facility staff for the Post Dialysis section. RN7 stated that the nursing staff are responsible for ensuring that the Pre/Post Dialysis communication form is completed entirely for every dialysis session that	F 842	Identification of Others All residents who receive hemodialysis treatments have the potential to be affected. Systemic Change All residents who receive hemodialysis will have a Pre/Post Dialysis communication record to avert the risk of an adverse event during or after the resident's treatments. Unit manager daily task added to check for completion of Pre/post dialysis communication record on a daily basis. Monitoring Change The Director of Nursing and/or designee will audit up to 5 random residents per week x 4 weeks for completion of pre/post dialysis communication record. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 37	F 842		

R58 attends.

On 05/04/22 at 03:58 PM, a concurrent interview and review of R58's Pre/Post Dialysis Communication records was done with the Director of Nursing (DON). DON confirmed that information was missing from R58's Pre/Post Dialysis Communication Records for 04/15/22, 04/27/22, and 04/29/22. DON stated the nursing staff are responsible for completing R58's Pre/Post Dialysis Communication form before and after each of R58's dialysis sessions. DON stated that the nursing staff are also responsible for ensuring that the Dialysis Center section of the Pre/Post Dialysis Communication form is also completed by R58's dialysis center.

2) On 05/05/22 at 08:11 AM the medical record for R85 was reviewed. Surveyor noted there was information missing from the Pre/post dialysis communication records on 03/23/22, 03/25/22 and 03/28/22. On the Pre/post dialysis communication page dated 03/23/22, there was no signature/ title or date/time completed by the staff at the dialysis center (the middle section on the page). There was no weight documented in the post dialysis section of the form or condition of access or change of site documented by the facility staff on the bottom of the form. On the Pre/post dialysis communication page dated 03/25/22, the dialysis center section was missing dialysis center name, nephrologist, telephone, contact person and temperature. The post dialysis section was blank, and the vital signs were crossed out with no note to indicate why. The Pre/post dialysis communication form dated 03/28/22 in the Pre-Dialysis section had vital signs documented and the rest of the assessment section was blank. The dialysis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 38 center section was missing the staff signature, date, and time. On 05/05/22 at 01:00 PM, surveyor reviewed facility's Dialysis Policy, effective date 04/24/19, Rev: 12.29.21. The policy stated, "Day of Dialysis: 3. Initiate the Pre/Post Dialysis Communication Form to be sent to the dialysis clinic with the resident ...Post Dialysis: 1. Obtain vital signs of resident upon return from dialysis and complete the Pre/Post Dialysis Communication form."	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		6/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to maintain infection prevention strategies for three of 18 Resident's (R)14, R24 and R41 in the sample. The deficient practice has the potential to increase the risk of illness for all residents residing in the facility. R14 and R41 were noted with improper hygienic practices regarding the placement of their urinals on top of the overbed tables where they receive meals. R24 was noted to be without the proper labeling of the nasogastric tube feeding set to indicate that it is changed daily. Findings include: 1) During a review of the electronic medical record for R41, it was noted that R41 is a 78-year-old male admitted with multiple medical diagnoses and complications including diabetes, heart disease, kidney failure, below the knee amputation and infections. Pharmacy note dated 04/25/02, stated that resident continues antibiotics (Fortaz 2 grams (gm) every 12 hours intravenous (IV), and doxycycline 100 milligrams (mg) twice per day for 14 days for left lower extremity wound infection. R41 also has a history of methicillin-resistant staphylococcus aureus (MRSA) (bacterial infection that is resistant to multiple antibiotics from heavy antibiotic use). On 05/03/22 at 09:23 AM, R41 was observed laying crossways on his bed with his right stump propped up on his overbed table. Next to his	F 880	F880 Infection Prevention & Control Corrective Action R41 urinal was removed from overbed table and was educated regarding infection control - proper placement for urinal storage. Director of Nursing disinfected the overbed table. R41 was alert and oriented x3 and able to independently use urinal and preferred to place urinal on his overbed table for convenience. R41 discharged on 5/7/2022. R14 no longer resides at the facility. R24 tubefeeding set and formula container was replaced on 5/3/2022. Identification of Others All residents who uses a urinal have the potential to be affected by this practice. All residents who require enteral nutrition have the potential to be affected by this practice. Systemic Change Facility purchased EZP urinal holder on a trial basis, with plans to affix to bed frame or drawer. Infection Prevention RN/designee will educate staff regarding disinfecting surfaces once contaminated (i.e. when urinal is placed on surface). Infection Prevention RN initiated education with RN on 5/4/2022 to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41 stump was a urinal half full of yellow liquid. His left foot was noted with a dressing. There was an IV bag hanging from the pole that indicated he was receiving the IV antibiotic. R41 stated that the nurse will be in soon to disconnect the tube. On 05/03/22 at 4:07 PM, during an observation in a different room, R14 was laying in his bed watching television. The surveyor noted there was an uncovered urinal sitting on the overbed table next to his bed with a moderate amount of yellow liquid. On 05/04/22 at 10:14 AM surveyor observed R41 sitting up on a wheelchair at his bedside with his right stump resting on his bed and his left lower foot was resting on the footrest and uncovered, open to air. On closer observation, the skin appeared to be peeled away with pink tissue and moderate clear serous fluid. The foot was swollen with pitting edema. The resident's urinal was sitting on the overbed table. Surveyor pointed out the urinal sitting on the table to the director of nursing (DON), who was also present in the room and asked if this was an appropriate place for the urinal and is there another place to put it besides the table where the resident eats his meals? The DON responded that the staff are reminded to thoroughly clean the overbed table prior to serving the meal trays and agreed that it shouldn't be placed there. The wound care team came into the room to evaluate R41's left lower foot. The wound consultant (WC) stated that R41 has peripheral vascular disease (PVD) from poor blood flow to the foot. The WC noted the skin breakdown from the swelling and oozing. He recommended R41 keep the leg elevated to decrease the swelling	F 880	enteral formula container is labeled and enteral administration set is labeled with date and time when it was first hung. Monitoring Change The Director of Nursing or designee will randomly audit up to 5 residents per week x 4 weeks to ensure enteral formula container and administration set is labeled. The Director of Nursing or designee will randomly audit up to 5 residents per week x 4 weeks to ensure urinal not on overbed table, and/or education provided to resident/staff. The results of the weekly audits will be reviewed monthly by the Quality Assurance Performance Improvement (QAPI) committee for a minimum of 1 month to ensure compliance is achieved and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 42	F 880		

and recommended not to leave the wound open to air. Clean with betadine and wrap with a kerlix gauze. R41 had a gangrenous wound to the right foot that wouldn't heal and resulted in a below the knee amputation. The priority is to save the left foot.
2) On 05/03/22 at 08:35 AM observed Resident (R)24's nasogastric (NG) tube and tube feeding formula, unlabeled and undated.

On 05/03/22 at 01:02 PM concurrent observation and interview with Unit Manager (UM)2 was done. UM2 confirmed R24's NG tube and tube feeding formula was unlabeled and undated. UM2 stated " ...usually there is a time, so you know when it started."

On 05/06/22 at 08:38 AM interview with Director of Nursing (DON) stated the tube feeding formula and NG tube should always have the resident's name and the date it was changed. DON further explained " ...just to make sure it's been changed out, so it doesn't get clogged, infection control, you don't want the same tube."

Review of the facility's policy and procedures on "Enteral Nutritional Therapy (Tube Feeding)" reviewed by the facility on 07/17/21 documents, "Make sure that the enteral formula container is labeled with the patient's identifiers; formula name (and strength if diluted)...Label the enteral administration set with the date and time that it was first hung, Change the enteral administration set according to the manufacturer's instruction to prevent bacterial growth."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey was conducted by the Office of Health Care Assurance on 05/03/22 - 05/06/22. The facility was found to be in substantial compliance with §483.73, Requirement for Long-Term Care (LTC) Facilities of Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/03/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	**91-575 FARRINGTON HIGHWAY** **KAPOLEI, HI 96707**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		6/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/03/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	**91-575 FARRINGTON HIGHWAY** **KAPOLEI, HI 96707**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 1 This REQUIREMENT is not met as evidenced by: K-363 Corridors-Doors This STANDARD is not met as evidenced by: Based on observation and staff interview with maintenance staff, the facility failed to maintain the fire door leading from the employee lounge into the exit corridor, in accordance with NFPA 101, 2012 edition, section 19.3.6.3.5. This deficiency could affect all residents, staff, and visitors during a fire in the employee lounge, which would prevent exiting from the exit corridor. Findings include: During facility survey on 5/4/22 at approximately 12:45 pm, revealed that the facility failed to maintain the fire door from the employee lounge in an operable condition. Upon testing of the operation of the door, the door failed to close and latch. These findings were verified at the exit conference with the facility manager and Administrator on 5/4/22 at 1:30 pm.	K 363	K363 Corridor-Doors Corrective Action Employee lounge fire door fixed and in operable condition as of 5/5/2022. Identification of Others All residents/staff have the potential to be affected by this practice. An audit was initiated on fire exit doors, with 100% completion by 6/10/2022. Systemic Changes Education initiated on 5/4/2022. All staff education will include, all fire exit doors must latch and if it is not operable, staff must report issue to the maintenance department (i.e. use maintenance log located in nursing station). Monitoring for Changes The Maintenance Director or designee will audit 5 random fire exit doors x 4 weeks to ensure fire doors are latching and in operable condition. The results of the weekly audits will be reviewed monthly by the Quality Assurance team for a minimum of 1 month to ensure compliance is achieved and maintained.	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99	K 911		6/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	**91-575 FARRINGTON HIGHWAY** **KAPOLEI, HI 96707**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 911	Continued From page 2 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: K-911 Electrical systems, Other This STANDARD is not met as evidenced by: Based on facility observation, the facility failed to maintain the electrical service room free from combustible storage, in accordance with NFPA 70, National Electric Code, 2011 edition, section 110.26 (B). This deficiency could affect all residents, staff, and visitors due to a potential fire in the electrical service room Findings include: During facility survey on 5/4/22, at approximately 12:30 pm, revealed that the electrical service room contained combustible storage items. These findings were verified at the exit conference with the facility manager and Administrator on 5/4/22 at 1:30 pm.	K 911	K911 Electrical Systems - Other Corrective Action The electrical room was cleared of any combustible items. Identification of others All residents/staff have the potential to be affected by this practice. Systemic Changes Education was initiated on 5/4/2022 regarding not using electrical room as a storage. All staff to be educated on where to store items. Monitoring for changes The Maintenance director or designee will audit the electrical room at least two times per week x 4 weeks to ensure that no items are being stored in the electrical room. The results of the weekly audits will be reviewed monthly by the Quality Assurance team for a minimum of 1 month to ensure compliance is achieved and maintained.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag	K 923		6/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	**91-575 FARRINGTON HIGHWAY** **KAPOLEI, HI 96707**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 3 CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	**91-575 FARRINGTON HIGHWAY** **KAPOLEI, HI 96707**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 4 This REQUIREMENT is not met as evidenced by: K-923 Gas Equipment-Other This STANDARD is not met as evidenced by: Based on observation and staff interview with maintenance staff, the facility failed to store type "E" type oxygen cylinders in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, section 11.3.3. This deficiency could affect all residents, staff, and visitors due to the storage of oxygen cylinders exceeding the 300 cubic feet limit in a storage area lacking sufficient safety features. Findings include: During facility survey on 5/4/22 at approximately 11:45 am, revealed that the facility had storage of "E" type oxygen cylinders in excess of 300 cubic feet in a non-rated room. These findings were verified at the exit conference with the facility manager and Administrator on 5/4/22 at 1:30 pm.	K 923	K923 Gas Equipment - Other Corrective Action On 5/5/2022 empty e-tanks were removed and oxygen storage room back in compliance with no more than 12 e-tanks total. Identification of others All residents/staff have the potential to be affected by this practice. Systemic Changes Education was initiated on 5/4/2022 regarding number of oxygen tanks permitted (12) at all times in storage rooms. Maintenance Director placed E-tank holder/rack with a capacity to hold 12 tanks in storage room. All staff to be educated on this practice. Monitoring for changes The Maintenance director or designee will randomly audit the oxygen storage room at least three times per week x 4 weeks to ensure there is only a total of less than or equal to 12 oxygen tanks in oxygen storage room. The results of the weekly audits will be reviewed monthly by the Quality Assurance team for a minimum of 1 month to ensure compliance is achieved and maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125051	A. BUILDING _____ B. WING _____	05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KA PUNAWAI OLA	91-575 FARRINGTON HIGHWAY KAPOLEI, HI 96707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments THIS FACILITY MET THE LIFE SAFETY REQUIREMENTS OF APPENDIX "Z"; IN ACCORDANCE WITH CFR 483.73, REQUIREMENT FOR LONG-TERM CARE (LTC) FACILITIES	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/03/2022

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.