STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on August 24, 2023. The facility was found not to be in substantial compliance with 42 CFR §483 Subpart B. Survey Dates: 08/21/23 to 08/24/23 Survey Census: 95 Sample Size: 22	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 residents regardless of payment source.	F 550		

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

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	A. BUILDING _____ B. WING _____	08/24/2023

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F 550	Continued From page 1 §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 observations, interview, and record review, the facility failed to treat one resident (R), R46, out of two residents sampled, with dignity and respect. This deficient practice has a negative effect on maintaining and enhancing R46's self-esteem and self-worth. The deficient practice has the potential to cause psychosocial harm to R46. Findings Include: R46 is a 76-year-old male admitted to the facility on 12/07/18. R46 has a diagnosis that include but is not limited to Parkinson's Disease. A review of his most recent Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 06/23/23 revealed that R46 was determined to have a Brief Interview for Mental Status (BIMS) score of 14, meaning he was found to be cognitively intact.	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 2	F 550		

Observation was conducted on 08/21/23 at 11:18 AM in R46's room. R46 was in the middle of eating a meal. A staff member was in the room handing him a drink. R46 was observed without pants or shorts on. R46 only had a shirt and his incontinence brief. He was not covered with a blanket.

Observation was conducted on 08/22/23 at 07:22 AM in R46's room. R46 was lying in bed with no shorts or pants on. R46 only had a shirt and incontinence brief on. He was not covered with a blanket.

Interview was conducted on 08/22/23 at 09:14 AM in R46's room. R46 verbalized that he would like to have shorts or pants on first thing in the morning but sometimes the staff do not put shorts or pants on him.

Observation was conducted on 08/23/23 at 07:10 AM in R46's room. R46 was seen lying in bed with his shorts pulled down below his hips, exposing his incontinence brief. R46 also had his shoes on. R46 remained in that position for 40 minutes until this surveyor called Certified Nurse's Aide (CNA) 44 into the room.

Interview with CNA44 was conducted on 08/23/23 at 07:50 AM in R46's room. CNA44 was queried on R46's shorts. CNA44 stated that R46's shorts were only placed halfway because R46 changed his mind on going into the wheelchair. CNA44 usually pulls it up once R46 was in a standing position. Since R46 changed his mind, CNA44 left him lying in his bed with his shorts down below his hips, exposing his incontinence briefs.

A review of the facility's policy titled, "Promoting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 550	Continued From page 3 and Maintaining Resident Dignity," with a review date of 01/10/23 was conducted. The policy indicated, "Groom and dress residents according to resident preferences."	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to document an interdisciplinary (IDT, includes but not limited to, the physician, social worker, dietitian, and nurse) assessment and care plan regarding a resident's self-administration of medication. The lack of this process failed to ensure that resident (R), R56, out of a sample of one, was assessed appropriately for having the capability to self-administer his medication safely and correctly. There also was no process to follow-up with R56 to ensure that he retained the capability to self-administer medication. This deficient practice could potentially harm residents who want to self-administer their medication(s). Findings Include: On 08/23/23 at 08:30 AM, conducted a concurrent observation and interview with Registered Nurse (RN)11 while administering R56's medications in R56's room. RN11 stated that R56 was able to administer his own medicated eye drops (Dorzolamide Hcl (Hydrochloride) - Timolol Mal Solution 22.8 - 6.8	F 554		

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

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F 554	Continued From page 4	F 554		

mg (milligrams)/ml (milliliter) to treat his glaucoma). RN11 stated that there was no documented assessment by the interdisciplinary team (IDT) and no care plan for R56 to self-administer his eye drops.

Record review of R56's electronic health record (EHR). "Order Summary Report" revealed "Dorzolamide HCl - Timolol Mal Solution 22.3 - 6.8 MG/ML Instill 1 drop in both eyes two times a day for Glaucoma *Space each drop by 5 minutes" ordered on 08/09/22. There was an order dated on 08/08/22, "May keep eye drops at bedside for self administration two times a day." No written documentation of an assessment by the IDT for the self-administration of medications was found nor was the self-administration of R56's eye drops was identified on R56's care plan.

On 08/23/23 at 11:52 AM, interviewed RN12 at the nursing station. RN12 stated that if a resident requests to self-administer medications, the resident is assessed by the nurse, but is not formally documented, to see if he/she is aware of and can identify him/herself, the place, time, and situation (alert and oriented four times). An order is then obtained from the resident's physician for the resident to be able to self-administer medications.

On 08/23/23 at 11:56 AM, interviewed Unit Manager (UM)2 in her office. UM2 stated that to self-administer medication(s), the resident needs to know the name of the medication and what it is used for, the dose, time, and correct procedure. UM2 confirmed that there was no formal and documented assessment done by the IDT for R56's capability to administer his own eye drops

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 554	Continued From page 5 to treat his glaucoma. UM2 agreed that R56's self-administration of his eye drops should be in the resident's care plan for proper monitoring of his continued capability. Reviewed the policy, "MEDICATIONS: SELF - ADMINISTRATION," with revision date 01/23/23. It stated, " ... Procedure: 1. The resident is determined by the Interdisciplinary Care Plan Team to be physically and mentally competent to self-administer medications. Use of self-medication will be addressed in the resident's care plan ..."	F 554		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party	F 622		

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 622	Continued From page 6	F 622		

payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

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F 622	Continued From page 7 (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure a safe and effective transition of care for three of five residents (R), (R64, R82 and R12) in the sample. The facility did not provide a copy of the comprehensive care plan goals to the receiving provider. This deficient practice does not provide an accurate picture of the resident and of his/her needs which will result in poor continuity of care. Findings Include: 1) During an interview on 08/22/23 at 09:01 AM, R64 stated he was recently hospitalized for low blood pressure and pneumonia (lung infection).	F 622		

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 622	Continued From page 8 Review of Electronic Health Record (EHR) revealed that R64 is a 90-year-old resident admitted on 10/13/22. R64 was transferred to an acute care hospital on 07/01/23 for non-ST-elevation myocardial infarction (less severe form of heart attack), respiratory failure, and pneumonia. Documented in the "Progress Notes" on 07/01/23 at 04:06 PM, ". . . Report including recent labs (laboratory results), AHCD (advanced health care directives), face sheet, med/tx (medication and treatment) list given to paramedics. . ." 2) During an interview on 08/21/23 at 02:54 PM, R82 said she was recently hospitalized for an infection to the surgical site on her abdomen. Review of the EHR revealed that R82 is a 72-year-old resident admitted to the facility on 07/18/23 for surgical aftercare. R82 was in the hospital for perforated bowels and colostomy (an opening for the intestines through the abdomen) creation. Review of progress notes revealed that R82 was sent to the emergency department for a blood transfusion on 07/22/23 but was admitted for an infected surgical site and returned to the facility on 08/02/23. On 08/23/23 at 09:30 AM, Social Worker (SW) 1 provided documents titled "Notice of Transfer / Discharge" for both R64 and R82. SW1 said they also fax a copy of the form to the State Long Term Care Ombudsman and email a copy to the residents' family along with the bed hold policy. When asked about what documents go to the receiving facility, SW1 said the facility has a checklist and the nurses print out the documents from the EHR.	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 622	Continued From page 9 On 08/23/23 at 12:25 PM, interview conducted with the Director of Nursing (DON) in the training room. Asked DON what documents are sent to the receiving facility when a resident is transferred out for a higher level of care. DON said the facility sends out a packet with the resident that included the face sheet, physician's orders, advance health care directives, medication administration record, treatment administration record, consultation notes, and laboratory results. The DON added that the nurse would also call the receiving facility to give report. When asked if the comprehensive care plan is also sent to the receiving facility, the DON said, "No, we do not send the care plan." 3) Record review of R12's EHR. R12 is an 86-year-old female admitted to the facility on 07/18/23 for cellulitis (inflammation of tissue) of left lower limb. On 07/25/23, R12 was transferred to the hospital for further assessment of left lower extremities. Further review of R12's EHR indicated no documentation of R12's care plans being sent over to the receiving hospital. Interview with DON was conducted on 08/23/23 at 12:25 PM in the training room. DON verbalized that the facility does not send over care plan records to the receiving hospital when a facility resident is transferred or discharged.	F 622		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

(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 656	Continued From page 10	F 656		

care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	A. BUILDING _____ B. WING _____	08/24/2023

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ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 656	Continued From page 11 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to develop and implement a comprehensive person-centered care plan for three of 22 residents (R)26, R34,and R64 in the sample. Care plans and interventions were not personalized to the needs of the residents. As a result of this deficient practice, the residents are at risk of not reaching their highest practicable physical and psychosocial well-being. Findings Include: 1) Cross Reference F692 Nutrition/Hydration Status Maintenance On 08/21/23 at 01:27 PM, observed R26 in her room with the main entree of her lunch not eaten. The whole broccoli pieces were not eaten and were two inches in length. The meal ticket on R26's tray indicated a regular diet with chopped texture. On 08/22/23 at 12:18 PM, observed R26 in her room with her lunch tray on her bedside table pushed to the left side of her bed. R26's entree of chicken and noodles were not eaten. The chicken piece was approximately 4.5 inches in length and 3 inches wide and not chopped. The meal ticket on R26's meal tray indicated a regular diet with chopped texture. Record review of R26's electronic health record (EHR). "Orders" revealed a diet order for	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 656	Continued From page 12	F 656		

"Regular diet, Chopped texture, regular/Thin consistency" with a start date of 08/08/22. Review of R26's latest care plan for the "Focus" for "Resident is at risk for fluid and nutritional deficit r/t [related to]: variable intake, underwt [underweight]/adult FTT [failure to thrive], malnutrition/severe PCM [protein calorie malnutrition], chewing deficit, CKD [chronic kidney disease, hx [history] wound." There was no indication for R26's need for a regular diet with chopped texture.
2) On 08/21/23 at 01:52 PM, observed R34 sitting up on wheelchair just outside her room. Noted right arm was bent and up against her torso, and the right hand was clenched in a fist. There was no splint for the arm and no rolled towel for the hand. On 08/23/23 at 03:43 PM, observed R34 lying in bed and slightly turned to her left side. A stuffed animal was placed between her right arm and torso. Right hand was clenched in a fist, no brace or rolled towel noted.

On 08/24/23 at 08:30 AM, review of R34's electronic health record (EHR) was done. R34 was admitted to the facility on 01/16/17. Diagnoses included hemiplegia (paralysis) and hemiparesis (weakness or inability to move) following cerebral infarction (stroke) affecting right dominant side. Review of comprehensive care plan with a revision date of 08/18/23 revealed there was no specific problem identified to address the resident's contracted right arm and clenched right hand.

On 08/24/23 at 09:48 AM, concurrent interview and record review conducted with Unit Manager (UM) 1 in her office. Asked UM1 what the facility was doing for her contracted right arm and clenched hand. UM1 said R34's right arm was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 656	Continued From page 13	F 656		

always contracted, and the staff use a pillow to keep it separated from her torso since it is also causing some skin irritations. UM1 also said R34's hand is mostly closed, and it is hard to open to put a rolled towel in it. Asked UM1 to check if there is a care plan in the EHR for the contractures and she was not able to find one.

3) On 08/21/23 at 09:59 AM, observed R64 sitting up in bed watching television. R64 said he was waiting for the staff to bring him outside so his transportation service can bring him to his dialysis (procedure to remove toxins and excess fluids from the body when the kidneys are not functioning) treatment. R64 had a central venous catheter (CVC, a surgically placed device providing access into a large central vein) on his right chest as his vascular access (a way to reach the blood for hemodialysis).

Record review of R64's comprehensive care plan dated 08/10/23. A problem identified for R64, was the need for dialysis. Interventions for identified problem included tasks to be done specifically for a fistula (vascular access surgically created by joining a native artery and vein) or a graft (vascular access surgically created by implanting a tube to join an artery and vein). These interventions were, "Assess bruit and thrill QSHIFT (every shift) . . . Do not draw or take B/P (blood pressure) in left arm with graft . . . Notify MD (attending physician) if evidence of loos of shunt patency." Further review of R64's EHR under "Misc" (miscellaneous), where facility upload paper documents, revealed that R64 used to have a fistula on his left arm. A scanned document uploaded on 12/20/22 stated that R64's fistula was ligated (closed off) due to rupture and a CVC was inserted on 12/16/23.

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain the nutrition status of one Resident (R)26 out of a sample of four residents. R26's diet texture was not provided to her according to the physician's order, which could potentially impact her dietary intake. This deficient practice rendered R26 under nourished and does not allow R26 to live at her highest practicable physical and psychosocial well-being. Findings Include: Cross Reference to F656 Develop/implement	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 692	Continued From page 15 Comprehensive Care Plan On 08/21/23 at 01:27 PM, observed R26 in her room with the main entree of her lunch not eaten. The whole broccoli pieces were not eaten and were two inches in length. The meal ticket on R26's tray indicated a regular diet with chopped texture. Record review of R26's electronic health record (EHR). "Orders" revealed a diet order for "Regular diet, Chopped texture, regular/Thin consistency" with a start date of 08/08/22. Review of R26's latest care plan for the "Focus" for "Resident is at risk for fluid and nutritional deficit r/t [related to]: variable intake, underwt [underweight]/adult FTT [failure to thrive], malnutrition/severe PCM [protein calorie malnutrition], chewing deficit, CKD [chronic kidney disease, hx [history] wound." There was no indication for R26's need for a regular diet with chopped texture. A task flowsheet for "NUTRITION - Amount Eaten" for R26's three daily meals from 08/11/23 to 08/23/23 revealed that R26 consumed 0 - 25% of the meal, 51% of the time. On 08/24/23 at 08:31 AM, interviewed Unit Manager (UM)2 in UM2's office. UM2 stated that R26's broccoli served for lunch on 08/21/23 and the chicken served for lunch on 08/22/23, was supposed to be initially chopped by the kitchen staff. UM2 further stated that the direct patient care staff serving the tray to R26 was supposed to double check the consistency of the meal and chop the appropriate food items if they were not done so by the kitchen staff. On 08/24/23 at 09:07 AM, interviewed the	F 692		

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 692	Continued From page 16 Registered Dietitian (RD) in the RD's temporary office. RD stated that a chopped consistency diet entails that harder textured foods are cut into ½ inch pieces. RD confirmed that not providing a chopped texture diet to R26 could render her with the inability to chew, causing her not to eat her meal, which then could cause her to become undernourished. On 08/24/23 at 10:12 AM, interviewed Kitchen Manager (KM) in KM's office. KM confirmed that the broccoli and chicken served to R26 for lunch were supposed to be chopped by the cook.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and interview, the facility failed to provide respiratory care that is in accordance with professional standards of practice for one Resident (R)64, out of one resident in the sample. The physician order for the use of oxygen did not include the type of delivery system, when to administer or discontinue the oxygen, and prescribed oxygen flow rates. This deficient practice could potentially cause harm to residents due to the lack of physician direction.	F 695		

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

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ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 695	Continued From page 17 Findings Include: On 08/21/23 at 09:59 AM, observed R64 sitting up in bed watching television. R64 had a nasal cannula (plastic tubing placed into the nares) connected to an oxygen concentrator set at 2.5 liter per minute. R64 said he was going out for his hemodialysis treatment and will not be back until later that afternoon. Review of the electronic health records (EHR) revealed that R64 was admitted on 10/13/22. Diagnoses includes but not limited to end stage renal disease (kidneys are not functioning) with dependence on renal dialysis (procedure to remove toxins and excess fluids from the body when the kidneys are not functioning) and chronic obstructive pulmonary disease (condition that causes airflow blockage and breathing problems). Comprehensive care plan reviewed, and a problem identified was "Risk for altered resp [respiratory] status." Interventions for this problem included, "Administer Oxygen as needed." Review of physician orders revealed an entry on 07/05/23 that stated. "O2 (oxygen) PRN (as needed). No other parameters were included in the order. On 08/24/23 at 10:39 AM, concurrent record review and interview conducted with the Unit Manager (UM) 1 in her office. Asked UM1 how the does the staff determine how much oxygen is administered to R64 and how to administer it. UM1 said the staff would refer to the order. UM1 then reviewed the oxygen order in the EHR and said, "They are supposed to specify how much oxygen to give and how to deliver it. I will correct the order and update the care plan."	F 695		

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

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ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 695	Continued From page 18 Review of facility policy "Oxygen Therapy" with a revision date of 07/24/23 stated, ". . . 4. The resident's physician orders shall identify the interventions for oxygen therapy, based upon the resident's assessment such as: a. The type of oxygen delivery system. . . c. Equipment setting for the prescribed flow rates. . ."	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 756		

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

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ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 756	Continued From page 19	F 756		

physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interview, the facility failed to communicate two medication recommendations, between the pharmacist and the attending physician, for one resident(R), R51, out of five residents sampled. As a result of this deficiency, the facility put R51 at risk for complications related to medications.

Findings Include:

Review of the electronic health record (EHR) showed R51 was admitted to the facility on 10/07/22 with diagnosis including Dementia, Diabetes, Post-Traumatic Stress Disorder, Hypothyroidism, and Depression.

Review of the Medication Regimen Review (MRR) document completed by the Pharmacist dated 02/23/23 read "... Will recommend clarification on diagnosis of Sertraline [antidepressant medication]..." There was no documentation that this was communicated to the attending physician.

Another review of the MRR completed by the Pharmacist dated 05/31/23 read "...Will recommend possibility of discontinuing evening

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

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ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 756	Continued From page 20 supplements to reduce pill burdens at bedtime ..." There was no documentation that this was communicated to the attending physician. During staff interview on 08/23/23 at 01:00 PM, Director of Nursing (DON) acknowledged there was no documentation to show that the two recommendations were communicated to the attending physician.	F 756		
F 761 SS=D	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	F 761		

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

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F 761	Continued From page 21 by: Based on observations, interview, and record review, the facility failed to ensure drugs and biologicals are stored in a locked compartment. Proper storage of medications is necessary to promote safe administration practices and to decrease the risk for diversion of resident medications. Findings Include: Concurrent observation and interview were conducted on 08/24/23 at 08:11 AM in the first-floor hallway. A medication cart was observed unlocked in the hallway with staff members, residents, and visitors walking by. This surveyor and Director of Nursing (DON) were present when Licensed Practical Nurse (LPN) 1 was interviewed. LPN1 stated, "I thought I locked it." He also added that medication carts should always be locked. A review of the facility's policy titled, "Medications: Storage," with a revision date of 01/11/23 was conducted. The document indicated, "All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) ..."	F 761		
F 812 SS=D	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	F 812		

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 812	Continued From page 22 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. §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 observations and interview, the facility failed to label food items with the dates they were opened to ensure they were not served after the expiration date. As a result of this deficiency, residents, visitors, and staff were put at risk for contracting a foodborne illness. Findings Include: On 08/21/23 at 08:07 AM, conducted the initial brief tour of the kitchen. Observed two thickener containers by the food preparation area that were opened. Both containers did not have a label to indicate when they were initially opened, and both were nearly empty. Observed an open bottle of cranberry juice on another counter that was half full and without a label indicating when it was opened. Interviewed Kitchen Manager (KM) in the kitchen at the end of the intial brief tour conducted on 08/21/23. Queried KM if the thickener and cranberry juice were supposed to be labeled and KM stated staff are supposed to put a sticker on the item with the open date and use-by date	F 812		

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 812	Continued From page 23 written on it. KM asked one of the kitchen staff to put a label with their respective dates on the containers.	F 812		
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; §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	F 880		

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	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 880	Continued From page 24 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. 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 observations, interview, and record review, the facility failed to completely screen visitors, guest, vendors for signs and symptoms of COVID-19. As a result of this deficiency, residents, staff, and visitors were at increased risk for contracting the COVID-19 virus.	F 880		

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F 880	Continued From page 25 Findings Include: Observation on 08/21/23 at 07:50 AM, there was a passive screening station for COVID-19 at the entrance to the facility. The station prompted visitors, guest, vendors to complete a screening questionnaire related to COVID-19. There was no staff in the immediate vicinity to monitor the station. Upon completion of the questionnaire, there was nothing provided to verify that the screening questionnaire was completed. The visitor, guest, vendor could enter the facility and there was no visual validation to show that the screening for COVID-19 was completed. On 08/21/23 at 08:07 AM, conducted the initial brief tour of the kitchen. Observed outside contractor for pest control walk into the kitchen area from the dining room without a mask. Asked outside contractor if he was supposed to be wearing a mask while in the facility, he said he was trying to find out. Outside contractor then asked Kitchen Manager (KM) if he needs to wear a mask. KM said, "Yes," and directed him to go to the screening area at the main entrance to get a mask. On 08/23/23 at 03:25 PM, interview conducted with Infection Preventionist (IP) by the first-floor dining area. Asked IP if everyone that enters the facility must wear a mask while in the facility. IP said, "Yes, we have postings in the front entrance and screening area." IP also pointed out a posting in the dining area titled, "Guidelines for Visitation", with an effective date of 05/01/23. The posting stated, ". . . Visitors will wear a facial covering/mask (nose and mouth covered) within the facility. . ." Asked IP if it includes outside	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125038	A. BUILDING _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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F 880	Continued From page 26 contractors like elevator maintenance workers, plumbers, electricians and exterminators. The IP responded, "Yes." Staff interview on 08/22/23 at 02:15 PM, the Chief Operations Officer (COO) acknowledged the observation previously mentioned that visitors, guest, vendors could enter the facility and there was no quick way to show that screening for COVID-19 was completed. COO revealed that there was supposed to be a sticker provided to everyone, after the completion of the screening questionnaire, but they ran out of the stickers and new stickers were currently on order. Review of facility procedure on "Guidelines for Visitation," effective 05/01/23, read the following: "... Visitation is allowed at all times, however please take into consideration sleep/wake times of residents, Visitors will be screened and observed for signs and symptoms of COVID-19 prior to visitation. If you are sick, have had close contact or have tested positive for COVID-19 refrain in person visitation ... Visitors will wear a facial covering/mask (nose and mouth covered) within the facility ..."	F 880		