DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125061	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAUAI CARE CENTER	**9611 WAENA ROAD , WAIMEA, Hawaii, 96796**

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E0000	Initial Comments A recertification survey was conducted by the Office of Health Care Assurance on 07/07/25 - 07/10/25. The facility was found to be in substantial compliance with 42 CFR §483.73, Requirement for Long-Term Care (LTC) Facilities of Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, State Operations Manual.	E0000		
F0000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) from 07/07/25 - 07/10/25. The facility was found not to be in substantial compliance with 42 CFR §483, Subpart B. In addition, three Facility Reported Incidents (FRIs), and one complaint were investigated. HI00011311: deficient practice not identified. HI00011576: deficient practice identified at F550 (past non-compliance) HI00011730: deficient practice not identified HI00011591: deficient practice not identified Survey Dates: 07/07/25 - 07/10/25 Survey Census: 45 Sample Size: 14	F0000		
F0550 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.	F0550	"Past Noncompliance - no plan of correction required"	

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0550 SS = D	Continued from page 1 §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. §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 the rights of one Resident (R) 198 of one resident sampled by ensuring the resident was treated with respect and dignity. R198 was receiving therapy from a staff member who spoke to her in a manner that R198 felt was disrespectful and demeaning, leaving R198 very upset. Findings Include: Facility Reported Incident (FRI) reviewed on 07/09/25 at 12:17 PM, intake #11576 for an incident that occurred on 03/12/25 at 02:41 PM involving a Physical	F0550		

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F0550 SS = D	Continued from page 2 Therapist (PT) 5 and R198. R198 reported to the facility staff that she was made to feel uncomfortable by PT5 regarding the way she spoke to her. R198 stated "I was going to the toilet, and she came into my room and opened the curtain and stated, "you are going to do therapy today," R198 told the PT5 that she was given a water pill and now must go to the bathroom more often. R198 stated that PT5 said "you are always crying wolf, every morning you have an excuse". R198 said "this is not the first time this has happened, but she did not want to say anything to get anyone in trouble. And said, "I feel threatened by her and do not want to do therapy". The Nurse Practitioner, (NP), Medical Director (MD) and Inter-disciplinary team (IDT) made aware of the incident. Facility investigation report reviewed on 07/09/25. The facility responded by placing PT5 on leave immediately, reported to MD, Administrator, and the State Agency (SA). Adult Protective Services (APS) was notified on 03/12/25 of an allegation of verbal abuse. The resident was reassured of her safety. An investigation was completed that included interviews with PT5, and the Charge Nurse, (CN) that was on duty. PT5 was interviewed by the Vice President and Regional Directors of Therapy Operations and provided with training on professional conduct, patient rights, and abuse prevention. PT5 concluded by stating she had no idea the resident was feeling this way at all and felt horrible about this, did not recall having any type of disagreements with the resident and continued to work things out with her. She supported the resident by continuing to encourage self-directed, resident choice and preference during her care. Concurrently, other staff and residents along with family members were also interviewed, no other reports received, observed or witnessed with or by residents, witnessed with other staff members or by family members. all other residents interviewed stated they felt safe, no residents reported being harmed. Follow up interview made by the Social Services Director (SSD) with R198. R198 expressed that she (PT5) talks like the mainland, and it is hard for her to comprehend when she told her "You're crying wolf", and thinks she needs to learn the ways in Hawaii. The resident was reassured that while it was not the intent of PT5 to offend her, it was not acceptable behavior or an acceptable practice of the staff here at the facility, R198 agreed and verbalized appreciation for all services received. R198 continued to state that she	F0550		

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F0550 SS = D	Continued from page 3 felt safe, was agreeable to continue to work with PT5 and all staff at the facility and will reside at the facility until she completed her short-term rehabilitation prior to returning to home, and verbalized understanding of her and all residents' rights of confidentiality and to report any further issues. R198 was placed on alert charting to monitor mood and behavior for possible psychological distress and signs and symptoms of psychological harm, the SSD made rounds on R198 to assess her emotional status and provide reassurance. Based on their investigation, the facility determined abuse did not occur. The facility concluded this was a misunderstanding of their standards of performance regarding acceptable customer service. The incident was reviewed by the Interdisciplinary Team (IDT) and it agreed immediate disciplinary action, training and a contingent performance plan was warranted. Random observations between 07/07/25 and 07/10/25 included interactions between PT5 and multiple residents in the Lokahi wing before, during and after therapy sessions. PT5 was observed to engage with the residents with a kind, caring and respectful manner. Observation and interview during a resident council meeting in the Lokahi dining room on 07/09/25 at 10:26 AM. The following residents were present: R3, R6, R14, R24, and R30. When asked if any staff treated them disrespectful or abusive. They all responded, no and that it is good here. They agreed that some of the staff are more friendly than others but they feel that the staff treat them well. On 07/10/25 at 10:07 AM, Administrator interviewed during the Quality Assurance Performance Improvement (QAPI) meeting in the conference room. When asked to explain the process that was put in place to ensure how the residents in the facility are provided with dignity and respect, and how the facility will monitor the effectiveness of the PIP, the Administrator explained that education of all the facility staff was included in the PIP. The staff education and sign in documents were reviewed. The Administrator discussed the PIP and provided a copy for review. The Administrative rounds were done weekly on 3/21/25; 03/24/25; 03/31/25;	F0550		

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F0550 SS = D	Continued from page 4 04/07/25; 04/14/25; 04/22/25. No negative interactions were observed. Resident Rights Policy revised dated 11/2016 reviewed on 07/10/25. Facility will honor resident rights as listed below: …Resident has the right to receive treatment and care with respect and dignity in a manner and in a safe, clean and homelike environment that promotes maintenance or enhancement of his or her quality of life and individuality, regardless of his or her payer source…	F0550		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.	F0583		

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F0583 SS = D	Continued from page 5 This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure that the personal information and clinical records of two resident (Resident (R) 35, R2) were protected. As a result of this deficient practice, residents are at risk of their health information not remaining private. Findings Include: 1) On 07/08/25 at 04:25 PM observed a facility computer in the common area was open with a resident's electronic medical record open exposing R2's personal and medical record for anyone to see. There were no staff in the area at this time. At 04:26 PM the Resident Care Manager (RCM) came to the common area. Inquired of RCM if the resident's record should be left open and she confirmed this was not supposed to be left open and she closed the record. 2) On 07/10/25 at 08:05 AM, observed Licensed Practical Nurse (LPN) 10, preparing meds for R35. When proceeding to give R35's medications, LPN1 walked away from the Electronic Health Record (EHR), which was on med card (located in the hallway at the Lokahi wing of the facility) and left R35's EHR open and accessible to other residents and visitors in the hallway. On 07/10/25 at 08:15 AM, Concurrent observation with LPN10 saw the open EHR. LPN10 stated he did not log off from EHR as it takes long to get back to the medication administration treatment (MAR) tab. When asked what the facility's practice is for the EHR when passing medications, LPN1 confirmed that he should have logged off and closed the EHR before walking away for privacy reasons and to comply with the Health Insurance Portability and Accountability Act (HIPAA). On 07/10/25 at 09:45 AM, interview with Director of Nursing (DON) confirmed that the EHR should be locked when walking away from the medication cart to maintain the resident's confidentiality and to comply with HIPAA. On 07/10/25 at 02:30 PM, reviewed the facility's "Automatic Log Off" policy. In the "Policy Objective" section, it notes, "To establish procedures to ensure any inactive electronic session results in a locked device preventing further access to information system that contain or access EPHI (electronic personal health information), and in the "Procedure" section, it notes, "All workforce members are required to logoff or lock their workstations prior to leaving the workstation	F0583		

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F0583 SS = D	Continued from page 6 unattended, or ensure the system will lock due to inactivity."	F0583		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F0655		

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F0655 SS = D	Continued from page 7 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to discuss the baseline care plan (BCP) and furnish a copy for one of three residents (Resident (R) 38) that was sampled for falls. Not providing the BCP to the residents, does not keep them informed of the initial plan for delivery of care and services they are to receive. Findings Include: On 07/07/25 at 01:30 PM, observed R38 in her room, sitting on the bed watching TV. Concurrent interview with R38 noted that the facility did not discuss her treatment plan with her upon admission, nor was given a copy of her baseline care plan. R38 verbalized, “I would remember something important like that.” On 07/07/25 at 02:00 PM, reviewed R38’s Electronic Health Record (EHR). R38 was admitted to the facility on 11/01/24 with medical diagnosis to include but not limited to lower back pain, diabetes, and generalized muscle weakness. R38’s Brief Interview for Mental Status (BIMS) assessment to assess cognitive and mental acuity of long-term care residents) score was noted to be 14 on the Minimum Data Set (MDS). The MDS is an assessment that is completed by facility upon admission and quarterly to assess the resident’s functional status. R38 BIMS’s score of 14 means she has little to no cognitive impairment. No BCP could be found or any documentation that it was discussed, or a copy given to R38 in progress notes. On 07/08/25 at 09:45 AM, Resident Care Manager (RCM) provided R38’s Resident Dashboard, which included R38’s care plan goals, but dashboard did not have any acknowledgement that it was discussed and received by R38. RCM also confirmed that there was no documentation in R38’s progress notes that the BCP was discussed and that a copy was provided to R38. RCM also confirmed	F0655		

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F0655 SS = D	Continued from page 8 that BCPs are important to be discussed with residents as it informs them of the care they will be receiving at the facility. RCM also stated that giving them a copy is important so that they have something they can keep for reference. On 07/08/25 at 02:30 PM, reviewed the facility's "BCP" policy. In the "Procedure" section, it states, "The facility will ensure the resident is presented with a summary of the BCP…resident/representative signature will be obtained, and this document will be scanned into the resident's clinical record."	F0655		
F0656 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 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	F0656		

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F0656 SS = D	Continued from page 9 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 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 staff interview and record review, the facility failed to develop a care plan to include diabetes management for one of five residents, R22, sampled for unnecessary medications. This deficient practice puts R22 at risk for diabetes related problems. Findings Include: On 07/09/25 at 09:00 AM, reviewed R22’s Electronic Health Record (EHR). R22’s was admitted to the facility on 12/04/23 with medical diagnosis that includes but is not limited to diabetes mellitus. Physician’s orders include Humulog injection solution 100 Unit/ml (insulin) per sliding scale initiated on 07/05/25, Glucose 15 Oral gel 40% dextrose, Glucagon Emergency injection kit 1mg injection as needed for hypoglycemic problems, blood glucose (BG) monitoring daily, notify provider if BG is less than 80 or greater than 250. R22’s care plan did not reflect any of the physician’s orders or any diabetic plan of care. On 07/09/25 at 09:30 AM, interviewed Registered Nurse (RN) 16 and reviewed R22’s EHR with RN16. RN16 confirmed that R22 was a diabetic and on insulin. RN16 also confirmed that there was no diabetes management included in R22’s care plan and there should have been one from the time R22 was admitted. RN16 confirmed that the development of the care plan is important as it directs the care and treatment for the residents. On 07/09/25 at 09:45 AM, interview with Resident Care Manager (RCM) confirmed that they have been trying to streamline their care plan process and agreed that a diabetes management plan should have been included in R22’s care plan.	F0656		

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F0656 SS = D	Continued from page 10 On 07/09/25 at 10:00 AM, reviewed the facility's "Care Plan Review Process" policy. In the "Purpose" section of the policy, it states, "To provide Regency Pacific skilled facilities an interdisciplinary process to ensure timeliness of each resident's person-centered, comprehensive care plan…" Reviewed the facility's Baseline Care Plan (BCP) policy, in the "Procedure" section, it notes, "Appropriate assessed and identified needs of the resident will be assessed and care planned with initial goals."	F0656		
F0657 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 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 review and revise the care plan for one out	F0657		

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F0657 SS = D	Continued from page 11 of three residents (Resident (R) 38) sampled for falls and one of one resident, R13 sampled for non-pressure skin condition. The facility failed to revise the care plan to remove the floor mats for R38 and R13's refusal to use Geri-sleeves (arm skin protector sleeves to keep arm safe from skin tears, bruising, and abrasion) to prevent further skin tears. This deficient practice puts residents at risk for not receiving the appropriate care and treatment needed to attain their highest practicable level of physical well-being. Findings Include: 1)On 07/07/25 at 01:30 PM, observed R38 sitting in bed. The bed was in low position with left side of bed flushed against wall. There was no floor mat noted on right side of bed. On 07/08/25 at 09:00 AM, observed in R38's room, no floor mat on right side of bed On 07/09/25 at 09:00 AM, observed in R38's room, no floor mat on right side of bed. On 07/09/25 at 09:15 AM, record review of R38 Electronic Health Record (EHR) noted that R38 was admitted to the facility on 11/01/24 with medical diagnosis to include but not limited to lower back pain, diabetes, and generalized muscle weakness. R38 also had six episodes of falls in the last six months. Concurrent interview with Registered Nurse (RN) 16 confirmed that the care plan for falls included fall mats on the right-side of the bed. RN16 accompanied surveyor to R38's room and noted there was no floor mat. RN16 verbalized that there must have been a change in R38's condition resulting in floor mat not in the room. RN16 agreed that if this was the case, the care plan should have been revised to reflect that change. On 07/09/25 at 09:30 AM, interviewed with Resident Care Manager (RCM). RCM stated Physical Therapist (PT) recommended to discontinue the floor mats on 05/20/25 as it was more of a hindrance for R38. RCM agreed the care plan should have been revised to reflect PT's recommendation on 05/20/25 to remove the floor mats. RCM stated that reviewing and revising the care plan is important as it direct the plan of care for their residents. 2) On 07/07/25 at 08:45 AM, observed R13 lying in bed. Noted bandages to right shin, right elbow and left arm. No Geri-sleeves to bilateral arm applied.	F0657		

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F0657 SS = D	Continued from page 12 On 07/08/25 at 09:45 AM, observed R13 in bed, no Geri-sleeves applied to bilateral arms. On 07/09/25 at 08:30 AM, observed R13 in bed, no Geri-sleeves applied to bilateral arms. ON 07/09/25 at 08:45 AM, reviewed R13's EHR and noted R13 was admitted to the facility on 03/29/23 with medical diagnosis to include but is not limited to Alzheimer's Disease, Psychotic Disturbance, Anxiety, and Diabetes. R13 has had four new skin tears in the last five months. R13's care plan noted a focus for "Potential alteration in skin integrity related to R13's weakness, deconditioning, and limited mobility. R13 also has fragile skin and numerous self-inflicted minor injuries to BUE/BLE (bilateral upper extremity/bilateral lower extremity)." In the "Interventions" section, it noted, "Geri-sleeves is to be applied in AM and taken off in PM." On 07/09/25 at 09:00 AM, interviewed RN16. RN16 verbalized that R13 is prone to skin tears. Reviewed R13's care plan RN16 and RN16 confirmed that she should have Ger-sleeves applied in the morning and taken off in the evening. RN16 noted that this was to prevent R13 from having further skin tears. On 07/09/25 at 09:30 AM, interviewed Resident Care Manager (RCM). RCM stated that they have tried to apply the Geri-sleeves on R13, but R13 becomes combative and will not let the staff put it on, so they have been leaving it off. When asked if R13's reaction or preference to leave the Geri-sleeves off should be noted in the care plan, RCM agreed that it should have been included and the care plan revised to reflect R13's preference. RCM further noted that the care plan should be reviewed and revised as it directs the care of the residents. On 07/10/25 at 10:00 AM, reviewed the facility's "Care Plan Review Process" policy. In the "Purpose" section, it notes, "To provide Regency Pacific skilled facilities an interdisciplinary process to ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised…"	F0657		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies	F0684		

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F0684 SS = D	Continued from page 13 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 observation, record review and staff interview, the facility failed to develop and implement a care plan for Resident (R) 28 who was one of one resident sampled for Rehab and Restorative, who had right hand contracture and should have a range of motion (ROM) care plan to assure R28's contracture does not worsen. This deficient practice puts R28 at risk for further worsening of his extremity contracture and does not promote R28's highest practicable physical, mental, and psychosocial well-being. Findings Include: On 07/08/25 at 12:30 PM interviewed R28 in the common area outside of his room. Inquired if he is working with the physical therapist (PT) and he stated he "graduated from therapy". During this interview observed resident pick up his right hand and arm with his left hand and bring it over to rest on his lap as he sat in his wheelchair. Observed R28's right hand has a contracture. R28 confirmed he is unable to use his right hand and arm. On 07/08/25 a Record Review (RR) of R28's Electronic Health Record (EHR) found he is a 75-year-old who was admitted to the facility on 08/29/24. Further RR found his diagnoses include, but are not limited to, muscle weakness, generalized; unspecified abnormalities of gait and mobility; acute diastolic (congestive) heart failure and personal history of transient ischemic attack (TIA); and cerebral infarction without residual deficits (stroke). R14's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/05/25 has him rated as having an impairment on one side (right) of his upper and lower extremity and dependent upon staff for lower body dressing and putting on and taking off footwear. R28 requires partial/moderate assistance with his upper body dressing and chair/ bed-to-chair transfer. R28 requires substantial/maximal assistance with toilet transfer, tub/shower transfer and walk 10 feet. R28 is independent once his food is delivered and can eat his food on his own and perform personal hygiene such as	F0684		

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F0684 SS = D	Continued from page 14 brushing his teeth and combing his hair. R28 is independent with rolling left and right in his bed and can wheel himself 50 feet make two turns in his wheelchair. Review of R28's MDS found he had a Brief Interview for Mental Status (BIMS) with a score of 15 out of 15 identifying him as cognitively intact. Review of R28's care plan did not show any interventions staff would do with resident to maintain his range of motion to prevent further contracture of R28's right arm. On 07/09/25 at 12:23 PM interviewed Therapy Director and inquired if R28 is doing therapy with her and she confirmed he had therapy with her from 03/27/25 – 06/02/25 for an evaluation. Inquired if she is the one who would give recommendations for resident's care, and she confirmed this. Inquired if she would be the one who would educate staff on exercises resident is to do and she confirmed this. On 07/10/25 at 07:55 AM requested a copy of R28's therapy care plan from the Resident Care Manager (RCM). RCM stated the Therapy Director would have this and she would bring surveyor a copy. On 07/10/25 at 11:15 AM RCM shared a copy of R28's care plan for therapy. At this time reviewed resident's CP with RCM and found there were no interventions for range of motion (ROM) and RCM confirmed it should have been there.	F0684		
F0761 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.	F0761		

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F0761 SS = D	Continued from page 15 §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 observations, interviews and review of the facility's Storage of Medication Policy, the facility failed to discard an expired bottle of stool softener in one of the three medication carts checked. The facility failed to properly label one resident's (Resident (R) 29) intravenous (IV) medication tubing and IV antibiotic. This deficient practice has the potential to affect residents in the facility that are prescribed stool softeners and IV antibiotics. Findings Include: 1) Observation on 07/07/25 at 11:25 AM in R29's room. The resident was lying in bed. Observed an infusion pump that was beeping. An intravenous (IV) infusion bag was hanging on the pole and the bag (manufacturer's label) read "Linezolid". No label was adhered to the bag to identify the name of the resident, the medication dose or the time it was administered. At 11:30 AM The Registered Nurse (RN) 10 came into R29's room to look at the IV pump. She said the line had air in it and that was why it was beeping. After resolving the problem, asked RN10 where the label was with the resident's name, medication name, , and time given. RN10 said, the label was on the outer bag from the pharmacy, I guess I should have removed it and placed it on the inner bag. RN10 concurred that there should be a label. When asked why R29 was on the antibiotics, she said, he has an open wound on his coccyx and that it is infected. Director of Nursing, (DON) interviewed on 07/07/25 at 12:06 PM. Observation made with RN10 was shared with the DON, no label on the resident's medication to include residents name, medication, dosage, and time the medication was started. The DON explained the pharmacy label's the outer bag, (the cover) that the medication came in from the pharmacy, and there should be a label on the bag.	F0761		

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F0761 SS = D	Continued from page 16 Observation and interview with RN 21 on 07/09/25 at 08:45 AM in R29's room. RN21 said she just hung the IV antibiotic for R29 and was observed with a foil package in her hand that had the label on the cover with the resident's name, the name of the medication, the dose and the time. RN21 was asked if there was a label placed on the bag (that was being administered) with the resident's name, the medication, dose, time given and date. Observed the bag that was infusing with RN21. RN21 confirmed that the medication bag did not have a label, but had a date and time written in pen on the bag. Discussion with the Resident Care Manager (RCM), the Director of Nursing (DON), RN10, and RN21 on the Lokahi unit at the nurse's station. The nurses discussed the IV antibiotic for R29 that does not have a label with the resident's name, drug, dose and time given on the actual medication bag that is provided to the resident. Discussed the problem with tearing the label off the outer bag to place on the medication bag. The label does not remove easily. The RCM stated that she will talk with the Pharmacist about obtaining a label with the required information to be adhered to the bag at the time the medication is administered. Interview via telephone call to the Pharmacy Consultant (PC)1 on 07/09/25 at 09:34 AM. Explained that the medication is sent from the pharmacy with a label on the outside sealed package and doesn't have a label on the inside package. When asked what the pharmacy recommendation is to label the medication bag. The PC1 said the expectation is that the facility will peel the label off the outer bag and affix it to the inner IV medication bag. The facility called this morning, and we had a discussion about the labeling. We will be sending an additional label with the resident's name, the medication name and dose that the facility will be able to affix to the medication. 2) On 07/09/24 at 09:30 AM, the medication cart located on the Laulima wing was checked with Registered Nurse (RN) 16. Observed a bottle of stool softener with an expiration date of 06/2025 in the medication cart. The bottle of stool softener was part of the facility's stock and used for residents that was prescribed stool softeners. Concurrent interview with RN16 noted that it should have been discarded. When RN16 was asked the importance of discarding expired medications, RN16 noted that expired medications should be discarded as	F0761		

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F0761 SS = D	Continued from page 17 it does not have the same efficacy and that it may not work effectively. On 07/09/25 at 12:15 PM, interviewed Resident Care Manager (RCM). RCM noted that the medication nurse should be checking for expired medications on an ongoing basis and discard them right away. RCM noted this is to ensure that medications given to resident are safe and effective. On 07/09/24 at 12:30 PM, reviewed the facility's "Storage of Medication Policy." It notes in the "Procedures" section, "14. Outdated, contaminated, discontinued or deteriorated medications…are immediately removed from stock, disposed of according to procedures for medication disposal…"	F0761		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §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(h) Medical records. §483.70(h)(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(h)(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-	F0842		

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F0842 SS = D	Continued from page 18 (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 by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(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(h)(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.	F0842		

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F0842 SS = D	Continued from page 19 This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview the facility failed to completely and accurately document two falls Resident (R) 8 had on 02/18/25 and 02/19/25. The deficient practice did not completely and accurately document R8's health status with two falls occurring within two days. Findings Include: On 07/08/25 Record Review (RR) of R8's Electronic Health Record (EHR) found her diagnoses include, but are not limited to, essential (primary) hypertension (high blood pressure); muscle weakness, (generalized); history of falling; cognitive communication deficit; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety involving emotional state; and personal history of (healed) traumatic fracture. Review of R8's care plan revealed R8 had a fall on 02/18/25 from her recliner and had a fall on 02/19/25 while attempting to ambulate unassisted. Review of R8's progress notes found the nurses assigned to care for R8 on 02/19/25 did not document what occurred with the 02/19/25 fall, such as the resident's health status, if she experienced any injury or pain from the fall and what care was provided to resident. On 07/10/25 at 09:17 AM interviewed Director of Nursing (DON) and inquired where documentation regarding R8's falls from 02/18/25 and 02/19/25 are and she stated it is in the incident report. Inquired where documentation for the falls was in R8's EHR as it was not seen in the resident's progress notes. DON reviewed R8's progress notes and stated there is a note on 02/19/25 regarding the 02/18/25 fall. DON stated she did not see the 02/19/25 fall documented in the progress notes. Inquired of the DON if it is the expectation of the facility for nurses to document resident falls in the progress notes and she stated not necessarily because it is documented in the incident report. Inquired of the DON if the incident report is included in R8's EHR and she denied this. Requested a copy of facility's documentation policy but this was not provided for review.	F0842		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880		

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F0880 SS = D	Continued from page 20 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 §483.71 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 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	F0880		

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F0880 SS = D	Continued from page 21 (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, interviews, and review of the facility's Hand Hygiene Policy, the facility failed to implement the facility's infection prevention and control measures. After providing peri-care and incontinent brief change for resident (Resident (R)13), staff did not perform hand hygiene and did not follow guidelines to prevent possible cross-contamination. These deficient practices placed the residents at risk for developing preventable infections and other adverse health complications. Findings Include: On 07/08/25 at 09:00 AM, observed Certified Nurse Assistant (CNA) 4 providing peri-care and brief change for R13. After completing task, CNA4 just walked out of the room without performing any hand hygiene. Concurrent interview with CNA4 noted that she forgot to wash or sanitize her hand before leaving the room. CNA4 stated that hand hygiene is important to prevent the spread of infection. Observed CNA4 proceed to sanitize her hand before proceeding down the hallway. On 07/09/25 at 02:00 PM, interviewed Infection Prevention Nurse (IPN). IPN noted that hand hygiene should be performed before and after resident contact, and before and entering the resident’s room. IP stated that this is important to prevent the spread of infections.	F0880		

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KAUAI CARE CENTER	**9611 WAENA ROAD , WAIMEA, Hawaii, 96796**

(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
F0880 SS = D	Continued from page 22 On 07/10/25 at 10:00 AM, reviewed the facility's "Hand Hygiene Competency Policy," It notes in the "Procedure" section, "Handwashing: Soap and Water, before and after assisting a resident with toileting, Handwashing either soap and water or Alcohol-Based hand rub: before and after direct resident contact, before and after assisting a resident with personal care, after handling soiled equipment, and after removing gloves or aprons…"	F0880		
F0908 SS = D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on interview and observation the facility failed to maintain Resident (R)28's wheelchair, allowing him to roll himself around with one spoke missing from his right wheel putting the resident at risk for injury. This deficient practice puts all residents in the facility who use a wheelchair at risk for injury if their wheelchair is not maintained in safe operating condition. Findings Include: On 07/08/25 at 12:30 PM interviewed R28 who reported he "graduated from therapy" and shared his wheelchair is broken it is "missing a spoke from the right wheel". Observation noted a spoke was missing from the right wheel of R28's wheelchair. On 07/09/25 at 12:23 PM interviewed Therapy Director (TD) and inquired if R28 is doing therapy with her and she confirmed he had from 03/27/25 - 06/02/25 (PT). Inquired about R28's wheelchair because he had shared, he wanted a different wheelchair. TD confirmed the wheelchair R28 is using is what is needed for his safety due to weakness on his right side and she has offered him multiple cushions for comfort. Inquired if therapist had ordered a new wheelchair for resident and she said she is not in the process of ordering a new wheelchair for him. Inquired about R28's wheelchair with its missing spoke and TD stated she was not aware of this, that resident had not told her. On 07/09/25 at 03:07 PM TD reported she changed out R28's right wheel on his wheelchair that was missing a spoke. TD stated she had not noticed it had a missing spoke.	F0908		