STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HI02LTC5064	A. BUILDING: _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOA COTTAGE - KAIMUKI	748 OLOKELE AVENUE HONOLULU, HI 96816

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4 000	11-94.2-0 Initial Comments An annual licensure survey was conducted by the Office of Health Care Assurance on February 28, 2025. The facility was found not to meet the regulatory requirements of the Hawaii Administrative Rules, Title 11, Department of Health, Chapter 94.2, Nursing Facilities. Survey Dates: February 27, 2025 to February 28, 2025 Census: 23 residents Sample Size: 4	4 000		
4 650	11-94.2-27 (4) Resident rights and facility pratices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observations, interviews and record review, the facility failed to promote the resident's right to a dignified existence and self-determination for one of three residents sampled and two random observations. As a result of this deficient practice, residents are at	4 650		

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4 650	Continued From page 1 risk for potential psychosocial harm. Findings include: 1) On 02/27/25 at 09:00 AM, conducted an interview with Resident (R)2. During the interview, inquired with R2 if staff treat the resident with respect and dignity. R2 stated, she does not want to complain, because resident does not want to be labeled as a bad person. Resident also added that she "feel the vibes." R2 also said that, whenever she asks the staff to give her shower every day, staff would tell her that they are too busy. Sometimes when she calls for assistance, staff sometimes ignores her even if she can see them passing by her door and she can hear them talking just outside her door. R2 also overheard one staff telling the other staff that she was being difficult every day. R2 stated, "It hurts my feelings hearing staff talk about me that way." R2 also wanted to be as independent as possible. R2 asked the staff if she can use her own wheelchair so she can wheel herself from her room to the common area around the facility, but staff did not listen to her request. R2 also said that she can still decide for her own care, but staff does not involve resident with her care. On 02/28/25 at 08:43 AM, conducted an interview with Registered Nurse (RN)2. Informed RN2 of R2's statement during my interview with the resident. RN2 confirmed that staff should use more discretion and awareness of how loudly they speak about residents and what they say about residents while giving reports to each other. RN2 also stated that staff should honor the resident's request for showering. RN2 was planning to talk with hospice care to increase frequency of R2's showering schedule from two to three times a week to once a day per resident's	4 650		

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4 650	Continued From page 2 request. On 02/28/25 at 02:46 PM, surveyor reviewed electronic medical record (EMR) for R2. Bathing and showering Task response history February 2025 indicated that showering or bathing with R2 were documented as done on February 2, 16, 18, 20, 23, and 25, 2025. 2) On 02/27/25 at 07:58 AM observed five residents seated at a table waiting for breakfast. RN2 apprached R5 with medicine. RN1 was head saying this is to help made "dodo". On 02/28/25 at 11:12 AM interviewed the DON. The observation on the morning of 02/27/25 of the nurse telling R5 in the presence of other residents that she was being given medication to help with "dodo" was shared with the DON. DON acknowledged this was a dignity issue and would follow up with the nurse. DON stated the nurse should inform the resident she is being given medication to help move her bowel. 3) On 02/27/25 at 11:45 AM observed RN1 assisting a resident with her meal. The resident was seated in a wheelchair and the RN was standing in front of the resident, hunched over her. RN was offered a chair to sit; however, preferred to stand. At 11:58 AM, the DON walked by and instructed RN to sit down during the mealtime. On 02/28/25 at 11:12 AM interviewed the DON. DON reported most of the staff sit when they are assisting residents with meals, it would be ideal to sit at eye level. DON fuirther shared feeding a	4 650		

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4 650	Continued From page 3 resident while sitting allows eye contact and promotes social interaction.	4 650		
4 700	11-94.2-27 (14) Resident Rights and Facility Practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (14) The right to personal privacy and confidentiality of personal and clinical records; and This Statute is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure that residents' personal information and clinical records were protected. As a result of this deficient practice, residents are at risk of their health information not remaining private. Findings include: On 02/27/25 at 02:00 PM, observed Registered Nurse (RN) 1 leaving the electronic medical records (EMR) screen with resident information open and visible after she walked away from the medication cart that was located in the hallway to give Resident (R) 6's medication. When asked what the facility's policy is for the EMR during medication administration, RN1 stated "The EMR should be exited out prior to leaving the medication cart, I'm so sorry, I forgot and will not	4 700		

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4 700	Continued From page 4 do it again." Second observation and concurrent interview on 02/28/25 at 08:00 AM, observed RN1 leaving the EMR screen open and visible again while giving R7's medication in the room. RN1 stated, "Oh no, I did it again." Review of the facility's medication administration guidelines notes on item #18 states that the residents' health information must remain closed and covered when not in direct use.	4 700		
4 885	11-94.2-41 (d) Storage and handling of food (d) In the kitchen and food preparation areas, receptacles shall be kept closed by tight-fitting covers, except in the kitchen during hours of food preparation and serving. [Eff] (Auth: HRS §§321-9, 321-11) (Imp: HRS §§321-9, 321-11) This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow food handling and storage practices in accordance with professional standards for food service safety. Unsafe and/or unsanitary food handling and storage practices have the potential to affect all residents, visitors, and staff who have meals served by the facility, placing them at risk for serious complications from foodborne illness as a result of their compromised health status as evidence by prepared foods were not labeled and dated, expired bag of cheese in the refrigerator, and open bag of frozen croissants in the freezer. Findings include:	4 885		

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4 885	Continued From page 5 On 02/27/25 at 07:43 AM, an initial tour of the facility's kitchen and interview with Cook Assistant (CA) were done in the kitchen area. Observed the following, a bag of cheese with expiration date of 12/30/24, an opened bag of frozen croissants in the freezer, and an unidentified food item in the refrigerator not labeled or dated. CA stated that she was unable to identify the food item, as she did not prepare this item. Asked CA if the bag of cheese was supposed to be discarded, and CA replied, "Yes, it's supposed to be discarded after the expiration date." On 02/27/25 at 12:17 PM, concurrent observation and interview with Administrator was done. Asked administrator if the bag of croissant are supposed to be kept closed and sealed, and administrator stated that, it's supposed to be kept closed and tightly sealed always. Administrator also added that, he will talk to the kitchen staff and in-service them about it. Review of the facility's policy and procedure "Food Storage" revised on 04/25/2023 documented, " ... 4. All packaged items once opened, should be labeled with an opened date. All facility made food, should be labeled with a cooked date ... 5. All opened items are good until the manufacture expiration date ..."	4 885		
4 935	11-94.2-42 (j) Physician services (j) Each resident shall receive age-appropriate immunizations or vaccinations including but not limited to pneumococcal and annual influenza vaccines and any necessary immunizations following the recommendations of the Advisory Committee of Immunization Practices unless otherwise contraindicated, or refused by the	4 935		

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4 935	Continued From page 6 resident, legal guardian, or surrogate. All immunizations provided shall be documented in each resident's medical record. [Eff] (Auth: HRS §§321-9, 321-11) (Imp: HRS §§321-9, 321-11) This Statute is not met as evidenced by: Based on interview and record review, the facility failed to offer influenza vaccine upon admission for 1 of 3 residents sampled.. As a result of this deficient practice, Resident (R) 1 is at risk for transmission of infectious diseases among the residents and contracting influenza. Findings include: On 02/28/25, record review of R1's medical records noted there was no influenza vaccination given on admission. The facility's policy on immunizations of residents notes that upon admission to the facility, permission must be obtained from the resident (or representative) to administer influenza vaccine annually (in the fall), unless contraindicated. On 02/28/25, at 12:00 PM, DON confirmed influenza vaccine was not offered on admission and will contact R1's daughter to get permission to administer today.	4 935		
4 945	11-94.2-43 (b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education.	4 945		

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4 945	Continued From page 7 This Statute is not met as evidenced by: Based on interviews with staff and record reviews, the facility failed to ensure the interdisciplinary team developed a plan of care for two of three residents in the sample, Residents 1 and 2. The facility did not involve Resident (R)2 or R2's representative in development of the care plan. The facility also did not include the use of bolsters for R1. This deficient practice failed to ensure continuity of care, and communication between facility staff and resident/ family members regarding care that is being provided to the resident. Findings include: 1) On 02/27/25 at 09:05 AM, conducted an interview with R2. During the interview, inquired with R2 if she was informed about her plan of care or participated in the care plan meeting. R2 stated that she does not know what the plan of care is, and staff did not inform her or include her in any meeting since she was admitted in the facility. R2 stated, "You know that saying, out of sight, out of mind." R2 also added that she is the primary decision maker for her overall health care other than her daughter. On 02/28/25 at 02:46 PM, surveyor reviewed electronic medical record (EMR) for R2. Reviewed care plan report with initiation date of 11/20/2024 documents, "The resident is dependent on staff etc. for meeting emotional, intellectual, physical, and social needs r/t (related to) Immobility, Physical Limitations." No further documentation found in the EMR to indicate the written care plan was provided to the resident, representative or her family.	4 945		

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4 945	Continued From page 8 During an interview on 02/28/25 at 09:27 AM, the Director of Nursing (DON) confirmed interdisciplinary care plan meetings are held quarterly in which the resident's plan of care is reviewed, evaluated, and updated. When asked if there is any form of documentation that resident or designee was included in the plan of care, DON said it should be in the resident's EMR, but unable to provide or show a copy to the surveyor. On 02/28/25 at 12:16 PM, conducted an interview with the Social Worker Designee (SWD). SWD showed communication record via text messages between hospice staff and SWD regarding maintaining involvement in cognitive stimulation and social activities as desired by resident. SWD further stated that no documentation was done in EMR and moving forward, she will make sure that focus, goals, and interventions will be documented in R2's plan of care. 2) On 0/27/25 at 07:45 AM, observed Resident (R) 1 in bed with bilateral pillow bolsters placed to the side of his body. R1 was trying to get up. The bed was in low position and fall mats were noted on the floor. The call light was placed right above R1's head. On 0/28/25 at 08:30 AM, interview with Registered Nurse (RN) 1 noted that bilateral pillow bolsters are used to prevent R1 from falling. RN1 noted that R1 had multiple falls since admission and the bolsters are used to help prevent falls. "Its something that the family suggested we do as they did that at home. R1 also has a bed sensor and floor mats." When asked if interventions to prevent falls has been successful, RN1 noted that it has helped decrease the number of falls R1 had since	4 945		

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4 945	Continued From page 9 admission. On 02/28/25 at 09:40 AM, interviewed the Director of Nursing (DON). When asked about the purpose of the pillow bolsters while R1 is in bed, DON responded, "The pillows are used to reposition R1 because he is not able to reposition himself. It is not used to prevent him from falling." Record review of R1's medical record noted that there were no physician's orders to use bilateral pillow bolsters while in bed. There was also no documentation in R1's plan of care for the use of pillow bolsters for either preventing falls or repositioning.	4 945		
4 950	11-94.2-43 (c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to complete a root cause analysis to determine the cause of Resident (R) 1's multiple falls to assist in revising interventions for fall prevention. The facility also failed to meet with the interdisciplinary team (IDT) to determine if current interventions were effective and determine the need for care plan revision. Findings include: On 02/28/25 at 09:40 AM, interviewed Director of	4 950		

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4 950	Continued From page 10 Nursing (DON). When asked what the facility's practice was after a fall, DON responded with "It should be documented, physician and family should be notified, and fall monitoring continued. We would do a root cause analysis to find out the reason for the fall. We don't change the care plan unless there is a reason to change it. The cause of R1's fall was that he was sliding out of bed and tries to get out of bed. In his mind he wants to get up. All falls were discussed with daughter, and she was made aware that we are a non-restraint facility." DON stated that the IDT did not meet to discuss R1's falls, but will add falls in their quality assurance plan intervention (QAPI) meetings moving forward. There was no root cause analysis documentation provided, and DON also noted that they should be adding a new intervention if previous interventions were unsuccessful. Record review of progress notes, incident reports, and care plan noted that R1 has had multiple falls since being admitted on 12/31/25. The first fall was on 1/08/25 at 07:02 AM, R1 was found on the ground and no injuries sustained. Care plan was reviewed and revised on 01/10/25 and initiated frequent checks: consider more frequent monitoring such as hourly rounds to ensure safety and comfort. On 01/15/25 at 06:20 AM, R1 was found on the floor, no injury sustained, care plan was reviewed and revised on 01/15/25 with intervention of Adequate lighting: ensure the environment is well-lit, especially at night or in dim lit areas. On 1/17/25, at 06:36 AM, R1 fell, while attempting to get up, hit his head, but no major injury noted. Care plan reviewed and revised on 1/17/25 and intervention of ensure bed and assistive equipment are positioned safely and are within easy reach. On 2/20/25 at 12:00 AM, R1 found on the ground, didn't sustain any	4 950		

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4 950	Continued From page 11 injuries. No care plan revision and review noted to address fall. The next care plan review and revision noted on 02/22/25, added intervention to encourage family members to visit for emotional support if possible. At 10:40 AM, reviewed the care plan with DON. When asked if the R1's 02/20 fall was addressed in the care plan, DON stated that R1's falls were discussed and all interventions are ongoing. DON further reported that interventions were not revised to address the last fall.	4 950		
41040	11-94.2-46 (j) Pharmaceutical services (j) Medication errors and drug reactions shall be recorded in the resident's chart and reported immediately to the physician, physician assistant, or APRN who ordered the drug, and a medication error report shall be prepared and given to the administrator of the facility or director of nursing for review and appropriate action, according to facility policy. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow the physician's orders for Resident (R) 6's blood pressure medication and failed to notify the physician and pharmacist of the blood pressure medication that was brought in by family. The facility also failed to obtain an updated order to use the 2 mg. dosage of Prazosin, prior to administering medication to R6. As a result of this deficient practice, R6 is at risk for medication errors. Findings include: On 02/27/25 at 02:00 PM, observed Registered	41040	Based on observation, interview, and review of the facility's policy and procedures, the facility failed to ensure medication cart was locked or attended. This deficient practice potentially increases the risk of injury for any resident, or visitor who can access the medication cart. Findings Include: During a medication administration observation on 02/27/2025 at 08:17 AM with Registered Nurse (RN) 2 on the first	

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41040	Continued From page 12 Nurse (RN) 1 giving R6, one capsule of Prazosin 2 mg., and one capsule of 1 mg. RN1 stated that the family brought in the Prazosin 2 mg. dose from home. On 02/27/25 at 02:30 PM, record review of R6's medical record noted physician's orders to give Prazosin 1 mg., 3 capsules twice a day. On 02/28/25 at 12:15 PM, interviewed Director of Nursing (DON) When asked what the facility's policy is on family bringing in medications for residents, DON stated, "The family has the option to go with our pharmacy or bring in medications for the resident. This is to save on the co-payment for some of the medications." DON noted if the dosage of medications from home doesn't match the physician's orders that they should call the physician and pharmacy to let them know of the medication brought in by family and get an updated order. Reviewed R6's electronic medical record (EMR) with DON and confirmed that the Prazosin order was for 1 mg., 3 capsules twice a day and that there were no orders found for Prazosin 2 mg. dose. The DON was asked whether this practice would result in medication error, DON agreed.	41040	floor, surveyor observed RN2 walked away from medication cart to go and administer medicine with Resident (R) 3 eating breakfast at the dining room. The medication cart was observed unlocked and unattended. After RN1 returned, surveyor asked RN2 if the cart should be locked and authorized personnel attends all times, and RN2 said, "Yes, it should be locked and attended at all times." On 02/27/2025 at 10:07 AM reviewed the facility's policy and procedure "Storage of Medication," dated (09/2018). The policy documents, "...Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access."	
41050	11-94.2-46 (l) Pharmaceutical services (l) All drugs, including drugs that are stored in a refrigerator, shall be kept under lock and key, except when authorized personnel are in attendance. The facility shall be in compliance with all security requirements of federal and state laws as they relate to storerooms and pharmacies.	41050		

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	HI02LTC5064	A. BUILDING: _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOA COTTAGE - KAIMUKI	748 OLOKELE AVENUE HONOLULU, HI 96816

(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) COMPLETE DATE
41050	Continued From page 13 This Statute is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedures, the facility failed to ensure medication cart was locked or attended. This deficient practice potentially increases the risk of injury for any resident, or visitor who can access the medication cart. Findings include: During a medication administration observation and concurrent interview on 02/27/25 at 08:17 AM with Registered Nurse (RN) 2 on the first floor, surveyor observed RN2 walk away from medication cart to administer medicine to Resident (R) 6 in the dining room area. The medication cart was observed unlocked and unattended. After RN2 returned, surveyor asked RN2 if the cart should be locked at all times, and RN2 said, "Yes, it should be locked and attended at all times." On 02/27/25 at 10:07 AM reviewed the facility's policy and procedure "Storage of Medication," dated (09/2018). The policy documents, "...Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access."	41050		
41140	11-94.2-55 (e) Housekeeping (e) All floors, walls, ceilings, windows, and fixtures shall be kept clean and in good repair. This Statute is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain a sanitary and clean shower room for one of the two shower rooms on the second floor. This deficient practice could	41140		

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	HI02LTC5064	A. BUILDING: _____ B. WING _____	02/28/2025

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MANOA COTTAGE - KAIMUKI	748 OLOKELE AVENUE HONOLULU, HI 96816

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41140	Continued From page 14	41140		

affect all residents at the facility if appropriate cleaning of the showers is not done.

Findings include:

On 02/27/25 at 08:00 AM, a walk through of the shower room closest to nursing station, observed black substance on the bottom floor caulking, starting from the left side bottom corner through the middle bottom and extending to the right side bottom corner.

On 02/28/25 at 08:10 AM, conducted an interview with the Housekeeper. When asked how often he cleans the shower room, Housekeeper stated, "I clean the shower rooms every day, but at different times during the day depending on the last resident shower schedule. I clean it with disinfectant." When Housekeeper was asked about the black substance in the shower room, housekeeper noted "I don't know what it is, but it's hard to to come off even when I try to scrub it." When Housekeeper was asked what is the process of reporting areas that needs to be cleaned and repaired, Housekeeper responded, "I tell the nurses about it and they supposed to let the maintenance supervisor know. It is the nurse's responsibility to report it."

On 02/28/25 at 08:20 AM, surveyor showed the black substance to Registered Nurse (RN) 1. When asked if she knew what the black substance was, she replied, "I don't know what it is, the housekeeper tries to clean it and I don't think it has been communicated to the maintenance supervisor."

On 02/28/25 at approximately 10:00 AM, Director of Nursing (DON) and Administrator accompanied surveyor to the shower room and were shown the

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	HI02LTC5064	A. BUILDING: _____ B. WING _____	02/28/2025

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41140	Continued From page 15 black substance on the caulking. DON verbalized, "I did not know about this, and this was just reported to me now. There was no work order." Administrator verbalized, "There is no way to prevent mold, we just have to replace the caulking." On 08/28/25 at approximately 02:00 PM, observed maintenance supervisor replacing caulking with the black substance in the shower room.	41140		