STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125064	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarence Tc Ching Villas at St Francis	2230 Liliha Street Honolulu, HI 96817

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on interview and record review, the facility failed to protect and promote patient's rights for 1 of 26 residents sampled (Resident (R)60) by ensuring that she was treated with respect and dignity. This deficient practice has the potential to affect all residents in the facility. Findings Include: R60 is a [AGE] year-old female admitted to the facility on [DATE] for wound care, and antibiotic and rehabilitative therapy. A review of her Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 10/30/24 noted R60 was determined to have a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. On 12/10/24 at 04:17 PM, an interview was done with R60 at her bedside. R60 described an incident where she fired a traveling nurse for repeatedly waking her for things that could have waited, such as unscheduled pain medication, and for not listening to R60 regarding the proper way to complete her dressing change. R60 reported she felt that Registered Nurse (RN)2 made her feel bullied, and was cocky. On 12/13/24 at 11:00 AM, an interview was done with Resident Care Manager (RCM)4 in the 4th floor activity room. RCM4 reported that she was made aware of a problem R60 had with RN2. RCM4 stated that as a result of the complaint from R60, she ensured that RN2 would not be assigned to R60 again and completed a grievance form. Review of the Resident Grievance/Complaint Form completed by RCM4 on R60's behalf on 12/06/24 noted the following: Guest with complaints of how nurse [RN2] provided wound care and felt she did not complete correctly. Guest did not appreciate how the nurse addressed her concern. RCM4 had initially described the nature of the grievance/complaint as complaints of nurse's bedside manner, then crossed out bedside manner and finished with wound care approach. The resulting staff education done to resolve the complaint did not address bedside manner, how to approach a resident, or cultural competency.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to identify, support, and honor the preferences of 3 of 11 Residents (R) sampled for Choices. Specifically, the facility failed to honor R60's and R79's preference to be informed of a time range that rehabilitation therapy services would occur and failed to honor R21's preference to be assisted outside periodically for fresh air. As a result of this deficient practice, these residents did not have their needs met and were placed at risk of not attaining their highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility. Findings Include: 1) R60 is a [AGE] year-old female admitted to the facility on [DATE] for wound care, and antibiotic and rehabilitative therapy. A review of her Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 10/30/24 noted R60 was determined to have a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. On 12/10/24 at 04:08 PM, an interview was done with R60 at her bedside. When asked about the right to make choices in her daily life that were important to her, R60 stated that not only does she not get to choose her therapy time, but she is also often not informed when it will happen since there is no scheduled time. R60 stated that she informed the facility from the beginning that she likes to go to therapy before lunch. She feels more energized in the morning and wants to do therapy before she is tired out from the day. R60 explained that at times the therapists will come in at 03:00 PM, with no prior notice that they were coming, and she has to tell them no because she simply does not have the energy. R60 reported that it is very upsetting to not know when therapy will happen. A review of R60's comprehensive care plan (CP) revealed the following: Resident has DX: [diagnosis of] Anemia and is at increased risk for activity intolerance . Adjust the intensity of activities to accommodate energy level and tolerance. Resident has depressed mood over current medical conditions . Allow resident to have control over situations, if possible. [R60] . has a preference to plan her own daily activities of their choice . Also noted during the review that there was no care plan created for her therapy preferences prior to 12/10/24. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/13/24 at 01:01 PM, an interview was done with the Director of Rehabilitation (DOR) in her office. During a concurrent review of R60's electronic health record (EHR), DOR confirmed that there was documentation that R60 had notified the therapy team on 11/06/24 that she preferred to have therapy in the morning only. DOR stated that in general, there is no schedule for when therapy will happen, but if a resident states their preference to be informed or for a particular time, the therapy team can work with the resident to create a schedule. DOR acknowledged that prior to 12/13/24, the team had not developed a therapy schedule for R60, despite her communicated preferences. 2) R79 is a [AGE] year-old male admitted to the facility on [DATE] for wound care, and antibiotic and rehabilitative therapy. A review of his MDS Admission Assessment with an ARD of 10/29/24 noted R79 was determined to have a BIMS score of 15, indicating no cognitive impairment. On 12/11/24 at 09:15 AM, an interview was done with R79 at his bedside. During the interview, a therapist popped his head in to inform R79 that he would be having therapy soon. After the therapist left, R79 expressed how frustrating it is that he never knows when therapy will show up. Stated he would like to be informed earlier what time they will be coming by so that he can prepare himself. On 12/13/24 at 10:53 AM, an interview was done with Resident Care Manager (RCM)4 in the 4th floor activity room. RCM4 confirmed that she does receive a lot of complaints from residents wanting to know what time they will be having therapy. Stated that when she receives a complaint, she lets the therapy team know. A review of R79's CP noted no care plan created regarding therapy preferences. 3) R21 is a [AGE] year-old male admitted to the facility on [DATE] for wound care, therapy, and skilled nursing services. A review of his MDS Admission Assessment with an ARD of 08/07/24 and his Quarterly Assessment with an ARD of 11/03/24 noted R21 was determined to have a BIMS score of 15, indicating no cognitive impairment. On 12/10/24 at 01:59 PM, an interview was done with R21 at his bedside. When asked about the right to make choices in his daily life that were important to him, R21 stated that he is frequently cold and often wishes he could go outside for some fresh air and sunlight. R21 reported that he stays in bed in his room every day and confirmed that the facility has not assisted him in going outside. A review of R21's CP revealed the following care plan, initiated on 08/02/24, identifying R21's activity preferences: [R21] . has a preference to plan his own daily activities . He enjoys . going outside for fresh air .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation and interview, the facility failed to provide privacy for one resident (Resident (R)274) and failed to protect the confidentiality of another resident's (R113) electronic health record. These failed practices have the potential to negatively impact the psychosocial well-being of the affected residents. Findings Include: 1) On 12/12/24 at 02:30 PM, while exiting the 3rd floor recreation room, made observations into room [ROOM NUMBER] at the end of the hall. Observed Certified Nurse Aide (CNA)3 assisting Resident (R)274 from the bathroom, located just inside the room entrance, back to her bed located next to the window. R274 was wearing a top that ended above her hips and an adult incontinence brief. CNA3 glanced at the State Agency (SA), observing from down the hall, yet neglected to attempt to preserve R274's privacy in any way, such as providing her with a towel or gown to cover, or by closing a door or privacy curtain. On 12/13/24 at 08:29 AM, an interview was done with CNA5 outside R274's room. CNA5 validated that R274 likes to wear only a top with her brief. CNA5 stated that when she assists R274 to the bathroom, she has R274 wear a gown and she will either hold the back of the gown closed for her, or she will shut a door to protect her privacy. On 12/13/24 at 08:40 AM, an interview was done with Resident Care Manager (RCM)5 at the 3rd floor Nurses' Station. RCM5 validated that staff should protect residents from being exposed by either providing a cover up, closing a door, or pulling the privacy curtain. 2) On 12/12/24 at 09:32 AM, an observation was made after exiting the elevator on the 5th floor. The medication cart to the immediate left of the elevators (medication cart #1), in front of room [ROOM NUMBER], had a laptop on it that was open and displaying the electronic health record for Resident (R)113. There were no staff members around the cart. At 09:34 AM, Registered Nurse (RN)8 returned to the medication cart from down the long hall. RN8 acknowledged she should not have left the laptop displaying protected information open and unattended.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on record review and interview the facility failed to provide Resident (R)107's completed Interact Nursing Home to Hospital Transfer Form to the hospital R107 was sent to when his condition changed and he became unstable, requiring a transfer and admission to an acute hospital. Findings Include: Record Review (RR) was done of R107's Electronic Health Record (EHR). On 11/17/24 Registered Nurse (RN) 25 documented R107 was sent to the emergency room (ER) because R107 complained of shortness of breath and could not breath and his Oxygen (O2) saturations were in the 70's. R107 was sent to the ER by 911 ambulance. Progress note dated 11/17/24 stated R107 was admitted to the hospital for diagnosis of AFib (Atrial fibrillation (AFib) is an irregular and often very rapid heart rhythm.). On 12/12/24 at 10:59 AM met with and interviewed Resident Care Manager (RCM) 5. Inquired where the documents are kept that were sent to the ER with R107. RCM5 stated the form is under the observation tab and labeled Interact Nursing Home to Hospital Transfer form. During this interview a concurrent RR was performed with RCM5 who confirmed this form was not filled out for this resident when he went to theER on [DATE]. RCM5 agreed this form would normally be filled out and sent with the resident to the hospital. RCM5 stated It's a communication for the change of condition, which includes care at facility along with point of contacts for the resident (R107). On 12/12/24 at 02:31 PM interviewed Registered Nurse (RN)25. Inquired about R107 who was transferred to theER on [DATE]. RN25 stated this was an emergency situation and she sent the resident with other documents the CCD, face sheet, and no POLST because he didn't have one. RN25 also stated she gave report to the hospital ER nurse. Inquired about filling out the form (Interact Nursing Home to Hospital Transfer form) and faxing it to the ER and RN25 confirmed she did not do this, she agreed she could have done this. RN25 stated the form is new, started about two months ago. On 12/13/24 at 08:46 AM met with and interviewed RCM5 and Nurse Educator (NE)1 who stated training on filling out the Interact Nursing Home to Hospital Transfer form is on new hire orientation and throughout the year during huddles. NE1 also explained a binder is left at all the nurse's station for nurses to use as a reference when sending a resident to the ER/hospital. Reviewed huddle rosters and did not see RN25's name on them. Inquired with NE1 and RCM5 if this is a new form and both denied this, NE1 stated the form is new for new staff. Requested for NE1 to check for training date for RN25. On 12/13/24 NE1 left a copy of the In-Service Attendance Record dated 09/13/24 for surveyor. The record stated SEND OUT: please ensure completion of the following: SBAR - Interact Transfer Form (send a copy or fax to ER ASAP if not completed before guest left and roster was signed by RN25. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility provided documents revealed facility provided training to nurses on Transfer to emergency room which states If guest is leaving via 911 you may not have enough time to complete the transfer form. Print all other paperwork and send with guest. You can always fax over the transfer form later (Obtain fax number from ER nurse). In-Service Attendance Record dated 07/22/24 states 4) SENT OUT NOTES: Document provider update, responsible party/ in case of Emergency notification, order, Name of hospital (EMS or AMR transport), sent out Dx (diagnosis), & list of what were sent with guest (EX: MAR, CCP, Transfer Form, POLST etc).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on record review, the facility failed to implement a comprehensive person-centered care plan to meet the medical, physical, and psychosocial needs for two of two Residents (R) 36 and R228 in the sample. The deficient practice has the potential to diminish both resident's quality of life. Findings Include: Cross reference to F698. Physical medicine and rehabilitation note 12/09/24 17:14 reviewed. R36 is a [AGE] year-old female admitted to the facility on [DATE] for subacute rehab services for decline in Activities of Daily Living (ADL's) and functional mobility after hospitalization . Care plan dated 11/15/24 reviewed. Approach: Check bruit and thrill. Assess site for bleeding. If bleeding, call the physician. Review of the medical record revealed there was no documentation of bleeding to the access site, or that it was reported to the physician (cross reference to F697). 2) Cross reference to F697, F684. Electronic medical record face sheet 11/29/24 reviewed. R228 is a [AGE] year-old female admitted to the facility on [DATE] for rehab services after a stroke. R228 receives pain management for leg and neck pain. Care plan reviewed. Problem: Resident has complaints of acute pain related to (R/T) Acute Cerebrovascular Accident (CVA), (stroke) and left sided weakness. Start Date 11/30/24 Approach: Monitor and record any complaints of pain: location, frequency, intensity, effect on function, alleviating factors, aggravating factors. Start Date 11/30/24 Approach: Assess effects of pain on the resident (disturbances in sleep, activity, self-care, appetite, psychosocial, etc.). Start Date (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/30/24 Review of the care revealed there were no interventions for the management of R228's pain.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on interview and record review, the facility failed to ensure the involvement of one resident (Resident (R)79) in the development of his comprehensive care plan (CP). As a result of this deficient practice, staff did not have all the information necessary to assist R79 in meeting his highest potential of physical and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility. Findings Include: R79 is a [AGE] year-old male admitted to the facility on [DATE] for wound care, and antibiotic and rehabilitative therapy. A review of his Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 10/29/24 noted R79 was determined to have a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. On 12/11/24 at 09:21 AM, an interview was done with R79 at his bedside. When asked about his participation in his care planning, R79 stated that he had not been invited nor had he participated in any care planning meetings. R79 expressed uncertainty what his current plan of care was, or how much longer he would be staying. Review of R79's electronic health record (EHR) revealed no documentation of an interdisciplinary team (IDT) discussion held since R79's admission. On 12/13/24 at 10:51 AM, an interview and concurrent record review was done with Resident Care Manager (RCM)4 in the 4th floor activity room. When asked about care planning, RCM4 stated that there is usually an IDT meeting done on admission, then once a quarter. RCM4 stated that the meeting and all discussed is usually documented in a progress note that is recorded by Social Services. RCM4 was unable to locate a progress note documenting IDT discussion but reported there was an Attendance Record, dated 11/15/24, indicating that an IDT meeting occurred. Referred State Agency (SA) to Social Services regarding what was discussed. On 12/13/24 at 02:32 PM, an interview was done with the Social Service Manager (SSM) in the 5th floor conference room. SSM confirmed that social services staff should have documented the IDT discussion in a progress note. SSM could not explain why the progress note was not created but confirmed that all social services staff were trained and expected to document the IDT discussion in a progress note. After further questioning, SSM acknowledged that it was possible the IDT meeting did not occur as planned.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on observation, interview and record review, the facility failed to provide resident centered care and services in accordance with the goals to meet the physical, mental, and psychosocial needs for three residents of 26 in the sample, Resident (R) 55, R228 and R34. Specifically the facility failed to meet R55's complex physical needs that resulted in frequent hospitalization s. Failed to schedule R228's Physical Therapy (PT) per her preference to coincide with her higher energy level in the morning and better pain management with as needed pain medication before PT. Failed to clarify and correct ambiguous insulin orders for R34 and failed to ensure standards of good clinical practice were followed with regards to documenting a hypoglycemic (low blood sugar) episode. As a result of this deficient practice, the facility placed R34 at risk for avoidable declines and injuries. This deficient practice has the potential to affect all residents on insulin. Findings Include: 1) Electronic Health Record (EHR) reviewed. Progress notes 11/04/2024 at 20:55 reviewed. Resident (R) 55 is a [AGE] year-old female resident admitted from a hospital to the facility on [DATE] for skilled nursing services. Primary diagnosis include Diabetic Ketoacidosis (DKA), (a serious illness resulting from high sugar concentrations in the blood), acute hypoxic respiratory failure, and community acquired pneumonia. Other diagnosis includes Diabetes Mellitus (DM) type 1; End stage renal disease on Hemodialysis (HD) and metabolic acidosis. R55 is alert and oriented and able to communicate her needs. Nurse's notes 11/22/24 18:25 reviewed. During her stay at the facility, R55 was transferred and admitted to an acute hospital on 11/15/24, 11/27/24 and 12/11/24. Om 11/15/24 R55 was admitted to an acute care hospital after complaining of not feeling right. Blood sugar 461, a very high level of sugar in the blood. Transferred to acute care at 0350. (Nurses notes 11/15/24 at 06:42 AM). R55 readmitted to the facility on [DATE]. Primary diagnosis: Acute hypoxemic respiratory failure/Pneumonia, Hyperglycemia with uncontrolled DM. Nurse's notes 12/04/24 at 16:16 reviewed. On 11/27/24 R55 transferred to the hospital for acute encephalopathy due to combination of urinary tract infection (UTI)/sepsis, hypoglycemia, and bacterial infection. Nurse's notes 11/27/24 at 07:27 AM reviewed. R55 was readmitted to the facility on [DATE]. Nurse's notes 12/12/24 at 00:15 reviewed. On 12/11/24, R55 was transferred to acute care facility. Urinary Tract Infection (UTI), sepsis, metabolic encephalopathy, and hypoglycemia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor asked the Resident Care Manager (RCM) 7 on 12/12/24 at 08:41 AM where R55 went, since her room had a different resident residing there. The RCM7 informed the surveyor that R55 was discharged to an acute care hospital the previous night due to a hypoglycemic episode, and very low blood sugar. EHR reviewed. Nurse's notes 12/11/24 at 15:13 reviewed. Upon initial assessment around 06:50 AM, guest appears confused and keeps on saying please. Blood glucose (BG): 249 milligram per deciliter (mg/dL). Routine Insulin 11 units given and 9 units per sliding scale administered. Offered breakfast but guest keeps on saying please eat breakfast. Notified and seen by Advanced Practice Registered Nurse (APRN). Rechecked BG at 08:50 AM and was 101mg/dL, appears diaphoretic. Offered 1 cup of orange juice with 2 packets of sugar, tolerated well. Helped guest to eat breakfast, able to eat 25-50 percent (%). No nausea or vomiting noted. Slowly got back to her baseline. Alert and oriented x 3. Rechecked BG at 0915 AM: 160 mg/dL. Medication Administration Record (MAR) 12/11/24 reviewed. Admelog SoloStar insulin pen; 100 unit/milliliter (ml); 7 units given before 5:00 PM. BG 162mg/dL. Boost Glucose Control 120 mL; oral before 17:00. 50% given to R55. Gvoke HypoPen 2 pack (glucagon) auto injector; 1 milligrams (mg)/0.2mL; 1 mg; subcutaneous (SC) prn inject subQ for BG less than 54 and notify MD. Not documented as given. Nurse's notes 12/11/24 at 21:41 reviewed. This writer spoke to guest at 06:15 PM, and another nurse was in the room with guest at 6:30pm. Guest was awake when dinner tray came, and aid continued to round and encourage guest to eat. Guest refused dinner and wanted to sleep. This writer rounded on guest at 7 PM and 8 PM, still sleeping during this time. Aid notified this writer that they could not wake guest. This writer found guest diaphoretic at 9:13 PM. Blood glucose 23 at 9:15 PM, MD on call notified. Glucagon 1mg/0.2mL subcutaneous given. Glucagon was not documented as given on the MAR. Emergency Medical Transport (EMT) arrived 09:31 PM and left at 09:41 PM. The facilities hypoglycemia management protocol date 12/16/19 reviewed. Hypoglycemia is defined by the American Diabetes Association as a blood glucose less than 70 mg/dL. Some patients have symptoms at higher glucose levels .For BG less than 70mg/dL and Patient Unconscious or Uncooperative or not eating by mouth (NPO) .Give 1 mg Glucagon SC x 1 and start intravenous (IV) access immediately (STAT) .Repeat BG and retreat every (q) 15 min until BG>70 mg/dL without symptoms or BG> 80 mg/dL .Document the episode, all blood sugar results, treatment administered, and any notifications/ change of orders given. Document response to treatment . Director of Nursing (DON) and the RCM7 were interviewed on 12/13/24 at 09:58 AM in the 3rd floor dining room. The surveyor asked why R55 was hospitalized . DON stated, R55 was hypoglycemic and went to the hospital. The licensed nurse gave her insulin. R55 told the licensed nurse that she didn't want to eat dinner. They said they continued to try to give her more supplement because she was not eating. When her BG dropped to 23, the Licensed Nurse (LN) gave her glucagon, and the attending provider was paged. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarence Tc Ching Villas at St Francis	2230 Liliha Street Honolulu, HI 96817

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked the DON and RCM7 why they think R55 has been hospitalized three times in the past 5 weeks. The DON said he thinks it is because she has a poor prognosis. The Advanced Practice Registered Nurse (APRN), saw her that morning because the licensed nurse noted she was confused. The APRN came to assess the guest, and her sugar was in the 160's then went to the low 20's the nurse gave her some orange juice with sugar, and she perked up. Telephone interview with the APRN on 12/13/24 at 11:45 AM. The surveyor asked the APRN the following questions. Why was R55 re-hospitalized so often, and if the facility is able to safely care for this resident with her complex medical conditions. The APRN explained that he saw R55 that morning and she was very altered. her blood sugar was 101, and it was classic hypoglycemia. She is immunocompromised, and each time she's transferred to acute care she has had infections. There is a follow up visit by the Diabetes team with her in the next 1-2 weeks. They considered a split insulin regimen but without her appetite, she will have the same problems. I think the scale may or may not have been appropriate. Endocrinology can give us further opinion. She is calibrated to a higher glucose level, and she gets very symptomatic when she's low in the 70's because she is usually high. When asked if R55 was stable enough for placement in the facility, the APRN said she would be better with a continuous glucose monitor and being stable should be criteria for R55 's readmission to the facility. Telephone interview with the Registered Nurse (RN) 15 on 12/13/24 at 12:45 PM. RN15 said at the beginning of the shift on the day of the incident, she had gotten report from the off going nurse in the morning and was told to watch R55 because she had a hypoglycemic episode in the morning. They encouraged her to eat 75% of her lunch and they left the boost at the bedside and asked if we can give it to her. I sat with her, I checked her sugar and took it again after she took half of her supplement. I rounded on her, Physical Therapy (PT) was there, and she was up and able to articulate to PT that she didn't want to participate. A while later, my aide came in and told me that she was sleeping a lot, then the aide and I checked on her and she was diaphoretic. I checked her blood sugar and it registered Low. We did sternal rubs on R55 to wake her up. I called the APRN, and the other nurse called the DON. I gave her an as needed (prn) order for the glucagon (an emergency sugar source). The surveyor asked RN15 if she thought that R55 is stable enough to stay in this facility? RN15 said, we're a skilled nursing facility (SNF) and Rehab facility. Because she's refusing PT and refusing meals, it raises other questions. She needs close monitoring and supervision, and there are other residents that also have care needs. 2) Cross reference to F697. An interview with the Family Member (FM) for R228 occurred on 12/13/24 at 02:28 PM. The surveyor asked him if R228 went to therapy today? The FM said not yet, we're still waiting. FM stated I talked to the RCM7 about scheduling her PT appointments at a set time and said, they aren't able to schedule them, and she didn't know what time R228 would go to therapy. FM asked the rehab staff at 11:00 AM what time she will go, and they said we don't know but she will have therapy today. When the surveyor asked the FM if the nurse will provide R228 with the pain medicine before therapy, the FM replied, it's really hard because we don't know what time she will have therapy, so how can the nurse give the pain medicine with enough time for it to take effect for her therapy session? 43245 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Resident (R)34 is an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that include, but are not limited to, insulin-dependent diabetes, chronic kidney disease, and heart disease. A review of his Minimum Data Set (MDS) Admission Assessment with an Assessment Reference Date (ARD) of 11/05/24 noted R34 was determined to have a Brief Interview for Mental Status (BIMS) score of 14, indicating he is cognitively intact. On 12/11/24 at 01:13 PM, an interview was done with R34 at his bedside. When asked about his insulin, R34 stated that he occasionally does have episodes of low blood sugar. On 12/11/24 at 01:34 PM, a review of R34's electronic health record (EHR) was done. Noted the following insulin order: Insulin Lispro 10 units twice a day. Special Instructions: Administer . Daily with Lunch and Dinner . TID [three times a day] with meals . Further review revealed that there was another insulin order, discontinued on 12/06/24, where R34 had been ordered insulin with breakfast as well, therefore had previously been ordered insulin three times a day. On 12/13/24 at 09:32 AM, record review revealed documentation that R34 had a hypoglycemic episode the previous night with a blood sugar of 63. This occurred after a blood sugar of 448 before dinner, and his insulin order being increased from 10 units to 12 units. Review of the progress note documenting the hypoglycemic episode revealed that it was documented on 12/13/24 at 08:24 AM, Late entry for 12/12/24 NOC [overnight] Shift ., and it did not include the time the low blood sugar occurred, the time interventions were applied, the time blood sugar was rechecked, or the time the Doctor was notified. On 12/13/24 at 10:22 AM, an interview was done with Resident Care Manager (RCM)4 in the 4th floor activity room. During a concurrent review of R34's EHR, RCM4 confirmed that the insulin orders were incorrectly put in as TID [three times a day]. After reviewing the progress note regarding R34's recent hypoglycemic episode, RCM4 agreed that the nurse should have documented the time that it happened. RCM4 also agreed that significant events such as low blood sugar should always be documented as soon as possible to when it happens and not left for an end of the shift note.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on record review, observation, and interview the facility failed to provide treatment and services to prevent complications of enteral feeding for one resident (Resident (R)10) in the sample. The facility did not ensure the formula bag was changed every 24 hours when enteral feeding was initiated using a bag past the stated discard date and time. This deficient practice has the potential to put residents on enteral feeding at risk for preventable complications. Findings Include: Record review of R10's Electronic Health Record (EHR) revealed the resident is an [AGE] year-old admitted to the facility for surgical aftercare following surgery on the digestive system. Diagnoses included but not limited to diverticulosis (condition in which pockets develop on the inside of the colon) and nontraumatic perforation of intestine. R10 had an order for enteral feeding (use of a feeding tube to supply nutrients and fluids to the body) four times a day. On 12/11/24 at 11:02 AM, observed Licensed Practical Nurse (LPN)5 initiate tube feeding for R10. LPN5 checked feeding tube placement and presence of residual prior to connecting the feeding bag that was on the feeding pump at R10's bedside. After setting the feeding pump to deliver the prescribed rate, noticed the label on the feeding bag had the date 12/10/24 written on it and the time was 11:00 AM. Asked LPN5 how often do they change the feeding bag and lines. LPN5 said, Every 24 hours. LPN5 then looked at the label of the feeding bag, immediately stopped the pump and said, I'll get a new set-up. and exited the room. Review of the facility policy titled Enteral Feeding Tube - Labeling stated, . tube feeding canister (bag, bottle, etc) and tubing is changed every 24 hours .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on observation, interview and record review, the facility failed to correctly dispense oxygen for one resident with a respiratory infection of two residents in the sample. The deficient practice may increase the resident's risk of illness. Findings include: 1) Electronic Health Record (EHR) reviewed. Physician order written on 12/10/24 at 07:36 AM reviewed. The Resident (R) 20 was diagnosed with Respiratory Syncytial Virus (RSV) and placed in isolation on droplet/ contact precautions. Minimum data set (MDS) admission assessment date 11/25/24 reviewed. R20 is a [AGE] year-old male admitted to the facility on [DATE]. Diagnosis includes complex medical conditions, Diabetes Mellitus, (DM), and Respiratory infection, (Pneumonia). R20 observed in his room on 12/10/24 at 11:47 AM wearing oxygen (O2) via nasal cannula (NC) and sleeping. The O2 monitor read in the off position. The Family Member (FM) was sitting at the bedside. FM said R20 was tested for RSV yesterday and today he had a positive test result. He was started on antibiotics yesterday and was really out of it. Today he is a little better. The surveyor went out of the room and inquired with the Resident Care Manager (RCM) 7 at 11:59 AM and asked what R20's order is for O2. RCM7 looked in the EHR and said the order is 1-4 Liters per minute (LPM) as needed. State surveyor stated to RCM7 that R20 is wearing the NC and the O2 appears in the off position. The surveyor asked her if the nurse charted in the EHR what the LPM was. RCM7 looked in the EHR and stated, it should be 1 L. Observation in R20's room on 12/11/24 at 10:25 AM. R20 was sleeping, the NC was placed incorrectly on the side of his face. The 02-meter was observed in the off position. The surveyor left the room and inquired with the Director of Nursing (DON) at 10:31 AM. The DON came into the room to observe R20 and concurred that the NC was incorrectly placed on R20, and said if he doesn't need 02, they should take it off and stow it properly after doing a respiratory assessment. Reviewed physician orders dated 12/09/24. Oxygen 1-4 LPM via NC for shortness of breath (SOB) or Oxygen Saturation (SpO2) less than (<)92 percent (%) as needed. Special Instructions: Notify Medical Doctor (MD) if O2 is applied or increased. Nurse's progress note dated 12/11/24 at 15:35 (03:35 PM) was reviewed and stated Oxygen - Room air challenge unsuccessful - guest presents 87% RA. -Assessed guest; re initiated oxygen 1LPM. [NAME] Pacific Health. Policy and procedure dept. Oxygen Administration. Effective date: 09/21/23 reviewed. Policy Statement. Oxygen is administered to a resident who needs it, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences . Procedures: Set flowmeter to rate ordered by the physician and place mask or cannula on guest/resident as ordered. A. Nasal cannula: Connect tubing to humidifier outlet and adjust liter flow as ordered. Place prongs of cannula into the guest/resident's nares.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38870 Based on observation, interview and record review, the facility failed to effectively manage the pain for one resident of 26 in the sample based on professional standards of practice. The deficient practice diminished the resident's quality of life due to decreasing the ability to successfully participate in Physical Therapy (PT) and family visit. Findings Include: Cross reference to F656 & F684. Observation and interview with Resident (R) 228 in the rehabilitation gym with her Family Member (FM) on 12/11/24 at 10:45 am, who said R228 is having a bad day and is in a lot of pain. R228 was speaking sharply in her native language with her face in a scowl. Surveyor asked the FM if R228 was medicated prior to coming to Physical Therapy (PT). He said no, but the nurse is going to bring the medicine now. The nurse came and gave R228 one Tramadol 25 milligram (mg) tab for the pain. The PT started doing exercises with R228's neck. The FM said that when he came in this morning that R228's was having very bad pain in her neck and knee. When the surveyor asked him if she received any pain meds this morning, he said he wasn't sure. PT notes 12/11/24 17:05 reviewed. Guest had breakdown just prior to PT session, son deferred treatment (tx) for today. Medication Administration Record (MAR) December 2024 reviewed. Tramadol - Schedule IV tablet; 25 mg documented as given on 12/10/24 at 04:56 AM, faces pain scale at 6/10; and 12/22/24 at 15:45 (03:45 PM) faces pain scale at 8/10. Observation and family interview in R228's room on 12/12/24 at 08:55 AM. R228 just finished her breakfast. The FM was at the bedside and said she's waiting for therapy. FM stated the nurses said they are going to change and give the pain medication before she goes to PT, but we don't know when they come, they just show up. Interview with the FM on 12/13/24 at 02:28 PM. The surveyor asked him if R228 went to therapy today. FM said not yet, we're still waiting (cross reference to F684). Orders reviewed: Gabapentin 100 mg capsule twice a day, 1 cap, oral, twice a day, dx. neuropathic pain 12/11/24. Lidocaine 4 percent (%) adhesive patch, medicate every 12 hours 1 patch, topical, for pain to left leg; 12 hrs. on (1700), 12 hrs. off (0500) 12/02/24. Tramadol 25 mg tablet every 6 Hours - as needed (PRN) 25 mg, oral, Every 6 Hours - PRN, for severe pain. 12/03/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS admission assessment dated [DATE] reviewed. Severely cognitively impaired and Cantonese speaking. Primary diagnosis of stroke and Diabetes Mellitus (DM). Has routine and as needed pain medication. Pain is present and has pain frequently. Pain is 10 on a numeric rating scale. Care plan reviewed. (Cross reference to F656).

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 38870 Based on observation, interview and record review, the facility failed to provide care and services for the provision of dialysis consistent with professional standards of practice for one of one resident in the sample. The deficient practice may increase the risk for an adverse outcome. Findings Include: Cross reference to F656. Observation and interview in Resident (R) 36 room on 12/10/24 at 2:20 PM. She stated that her hemodialysis access site is in her left arm, and sometimes after her dialysis session, the site continues to bleed. When that happens, she has to keep a dressing with pressure to the site. Observation and interview in R36 room on 12/12/24 at 8:30 AM with the Registered Nurse (RN) 35. R36 had an ace wrap to her left upper arm, she stated that she had bleeding to her arterio-venous fistula (AVF) after her dialysis last night. RN35 stated, we will keep the wrap on a while longer. Observation and interview with R36 in her room on 12/12/24 at 1:00 PM, she still had the ace wrap on her left upper arm, she stated that she usually keeps it on for one day when she has bleeding after dialysis. Electronic Health Record (EHR) reviewed. Dialysis communication form dated 12/11/24 reviewed. No concerns documented by facility RN or Dialysis RN regarding bleeding to the Left (AVF) or that a dressing was applied. Nurse's note dated 12/11/24 at 23:09 reviewed: RN POST HD. Guest returned to facility at 2140 wheeled by staff in stable condition. Left (AVF) positive (+) bruit and thrill with no active bleeding noted to site. No documentation in the progress notes regarding bleeding to the LAV fistula or that a dressing was applied. There was no documentation that the bleeding was reported to the Medical Doctor (MD). Interview with the Director of Nursing (DON) and Resident Care Manager (RCM) 7 in the 3rd floor activity room on 12/13/24 at 10:31 AM. The surveyor asked them if there is any documentation in the EHR about R36's post dialysis bleeding at the LAV site. The DON looked in the EHR and said it should be on the Dialysis form and the interact tool. The surveyor confirmed with the DON and RCM 7 there was no documentation found on the Dialysis communication form or the progress notes or that the MD was notified by the nurse. Care plan reviewed, (cross reference to F656). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facilities policy and procedure for Hemodialysis states- Care of Resident 08/27/24 reviewed. Procedure . Assess patient after hemodialysis treatment by checking for at least the following: b. Pressure dressing post dialysis will not be removed from the AVF site for a minimum of 4 hours. Monitoring of access site - after dialysis check for bleeding. If bleeding occurs, apply direct pressure until it is controlled. Notify the provider if bleeding lasts long than 30 minutes or is severe. Upon return the dialysis access site will be checked every 1/2 hour x 4 then every hour x 2 .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47783 Based on observation, interview, and record review, the facility failed to ensure medications of discharged residents, and medications that were past their discard date are disposed of and not administered to the residents. The facility also failed to implement a thorough process to assure accurate reconciliation and accounting of all controlled medications, for 1 of 12 medication carts, in order to promptly identify loss or potential diversion. Findings Include: 1) On 12/12/24 at 08:51 AM, inspection of one of the medication carts on the fifth floor was conducted with Registered Nurse (RN)8. An open box Wixela Inhub (inhaler medication for asthma) was found in one of the drawers. The box had a label where the open and discard dates were written. Discard date stated 12/09/24. Asked RN8 if a dose of the Wixela Inhub was administered to the resident recently. RN8 said Yes, I administered a dose this morning. Showed RN8 the label with a discard date of 12/09/24. RN8 said she will discard the medication and get a new one. 43245 2) On 12/12/24 at 10:57 AM, while inspecting medication cart #2 on the 3rd floor, noted the Narcotic Count Sign In Sheet had not been signed by the off going and oncoming nurses for 2 shifts. Interview with Registered Nurse (RN)6 confirmed off going and oncoming nurses should both initial on the log to attest the narcotic count had been done and was correct. RN6 agreed without it being signed off, there was no documentation the narcotic count actually took place. Review of the facility policy and procedure, Controlled Medication Storage, last updated 01/24, revealed the following: At each shift change or when keys are surrendered, a physical inventory of all controlled substances . is conducted by two licensed nurses . and is documented on the controlled substances accountability record or verification of controlled substances count report.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43245 Based on observation, interview, and record review, the facility failed to ensure all medications used in the facility were stored and labeled in accordance with professional standards. Proper storage and labeling of medications is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility who take medications. Findings include: 1) On 12/12/24 at 08:16 AM, while conducting an inspection of the medication storage room on the 4th floor, found a bottle of magnesium citrate that had a manufacturer's expiration date of 10/24, and a bottle of Colace liquid with a manufacturer's expiration date of 10/31/24. On 12/12/24 at 08:32 AM, conducted an interview with Resident Care Manager (RCM)4 in the medication storage room. RCM4 stated that she checks the medication storage room every week for expired medications. Acknowledged the two medications were missed and should have been identified and discarded. 2) On 12/12/24 at 08:34 AM, observed an unlocked medication cart outside room [ROOM NUMBER] with no staff in sight. At 08:35 AM, RCM4 approached the cart and validated that the nurse responsible for the cart (medication cart #3) should have locked it before walking away. At 08:37 AM, Registered Nurse (RN)10 returned to medication cart #3 and acknowledged that she should have ensured it was locked before she walked away from it. On 12/12/24 at 11:15 AM, observed an unlocked medication cart on the 5th floor (medication cart #1). Almost immediately, RN8 came running from down the hall and locked the cart. RN8 acknowledged she should have secured the cart prior to walking away from it. Review of the facility's policy and procedure Storage of Medication, last updated 01/24, revealed the following: Medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized access. 3) On 12/12/24 at 09:55 AM, while conducting an inspection of the medication storage room on the 5th floor, observed an open vial of Tubersol (tuberculosis vaccine) in the refrigerator that was not labeled with an open date or a discard date. On 12/12/24 at 09:59 AM, an interview was done with the Resident Care Manager (RCM)3 in the 5th floor medication storage room. RCM3 confirmed the Tubersol found in the refrigerator was opened and unlabeled. RCM3 also validated that since it was not labeled when it was opened, she had no idea if it was still good and therefore needed to be discarded.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43245 Based on observation and interview, the facility failed to ensure the ice and water equipment for the residents were kept in clean and sanitary conditions in accordance with professional standards for food service safety. Residents risk serious complications from foodborne illness as a result of their compromised health status. Unsanitary food handling and/or equipment maintenance practices represent a potential source of pathogen exposure for all residents receiving ice or water on the affected floor. Findings include: On 12/10/24 at 12:15 PM, an inspection of the resident nourishment room on the 4th floor was done. Observed a buildup of hardened brown sediment/material around the bottom edge of the plastic chute dispensing water and ice for the residents. A concurrent interview was done with Registered Dietician (RD)1 who was present in the nourishment room. RD1 stated that Maintenance was responsible to clean the ice and water machine. While RD1 could not say what the brown buildup was or if it was acceptable, RD1 did agree that the ice/water dispenser should be cleaned regularly and confirmed that it was used daily to provide hydration to the residents on the 4th floor. On 12/10/24 at 12:29 PM, interviews were done in the 4th floor nourishment room with Maintenance Associate (MA)2 and the Facilities Coordinator (FC). MA2 stated that he cleans the ice/water dispenser every Saturday, so it had just been cleaned three days ago. When asked to see the maintenance log, MA2 reported that he does not keep a log of the weekly cleaning. Concurrent observations were done with MA2 and FC of the brown buildup on the plastic chute. Both agreed that while calcium deposits could not be entirely avoided, those deposits are white in appearance and did not explain brown sediment. They also agreed that a buildup of brown sediment/material should be avoided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783 Based on observations, interviews, and record reviews, the facility failed to implement infection prevention and control measures. Specifically, the facility did not ensure that staff were wearing applicable personal protective equipment (PPE) when providing care to a resident on transmission-based precautions (TBP) and perform hand hygiene after exiting the room and between glove changes. This deficient practice placed the residents at risk for the potential spread of infections and communicable diseases. Findings include: 1) On 12/10/24 at 12:38 PM, observed Certified Nurse Aide (CNA)38 deliver lunch tray to Resident (R)323. Signage was posted on the left side of the door to R323's room that stated he was on contact precautions and staff must clean their hands before entering and when leaving the room, wear gloves and gown before entering the room. CNA38 entered R323's room without donning gloves and gown to deliver his lunch tray and did not perform hand hygiene after exiting the room. Asked CNA38 if she was supposed to wear PPEs before entering the room and showed posting on the left side of the door. CNA38 said, I did not see the posting because this is not my regular floor. Asked CNA38 if she washed her hands after exiting the room. CNA38 acknowledged she did not and proceeded to wash hands with soap and water. Review of the facility policy titled Contact Precautions stated, . Gloves should be worn when entering the room and while providing care for a resident . removed before leaving the resident's room and hand hygiene should be performed immediately. A gown should be worn when entering the room . 37954 2) Record Review (RR) was done of R44's Electronic Health Record (EHR) which revealed R44 is an [AGE] year old who was admitted to the facility on [DATE] with a diagnosis that includes, but is not limited to, history of stroke and is totally dependent on staff for his care. R44 developed a stage 2 pressure ulcer (PU) on his sacrum at the facility which has progressed to a stage 4 PU and is also documented as a [NAME]/Terminal Ulcer. R44 is receiving wound care from an outside wound specialist every week and dressing changes are provided by facility wound care nurses and facility nurses as ordered by the physician. On 12/12/24 inquired of Resident Care Manager (RCM) 5 when R44's dressing would be changed and she said the wound specialist comes every Friday and the dressing change will be done at that time. Surveyor requested RCM5 arrange for surveyor to observe this dressing change. On 12/13/24 at 10:00 AM observed dressing change to R44's sacrum that was performed by wound specialist and facility wound care nurse, Registered Nurse (RN)32. After wound specialist left R44's room RN32 continued with the dressing change to R44's sacrum. RN32 cleansed site, packed the wound and applied an abdominal pad to R44's sacrum. RN32 changed gloves frequently during dressing change but did not perform hand hygiene between each glove change. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125064	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarence Tc Ching Villas at St Francis	2230 Liliha Street Honolulu, HI 96817

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/24 at 02:00 PM interviewed RCM5 and inquired about what is expected of staff when they take off gloves and put on new ones and she stated staff are expected to wash their hands or use hand sanitizer between glove change. Inquired if staff are trained on this and she stated this is reinforced during training and huddles.