STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125063	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
15 Craigside	15 Craigside Place 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interviews and record review, the facility failed to provide a written Notice of Medicare Non-Coverage (NOMNC) at least two days before the end of services covered by Medicare for one of three residents (Resident (R)22) sampled. As a result of this deficient practice, the responsible party is unable to file an immediate, independent medical review (appeal). Findings include: On 06/20/25 at 10:00 AM, conducted a review of three NOMNCs provided by Social Worker (SW)33. Review of R22's NOMNC documented Medicare Coverage of the resident's skilled nursing services will end on 01/16/2025. However, the form was signed on 01/17/2025 after coverage ended. On 06/20/25 at 10:22 AM, conducted an interview with SW33 regarding R22's NOMNC. SW33 reported the NOMNC was signed a day later because that is when the resident representative came in to sign the form. Requested for any additional documentation that R22's resident representative was notified of the appeal rights prior to 01/17/25. At 10:53 AM, SW33 confirmed R22's NOMNC form was not provided within the required timeframe (two days) to allot the resident representative right to appeal.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2025
NAME OF PROVIDER OR SUPPLIER 15 Craigside		STREET ADDRESS, CITY, STATE, ZIP CODE 15 Craigside Place Honolulu, HI 96817	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews and record review, the facility failed to ensure one resident (Resident (R) 15) received adequate assistance to prevent an avoidable fall. R15 does not have the functional ability to support her trunk while sitting at the side of the bed. One staff attempted to dress R15's upper body while the resident was sitting on the side of the bed. Staff was unable to maintain the resident's body position, the resident hit her head on the bedrail and fell to the ground on her left side. As a result, of this deficient practice, the resident sustained a laceration to the forehead which required stitches and a displaced fracture of the first cervical vertebra. Prior to the start of this recertification survey, facility had corrected this deficient practice resulting in past non-compliance. Findings include: On 06/18/25 at 02:18 PM, conducted an interview with R15's Family Member (FM) 4. FM4 was informed by staff that R15 fell while staff was assisting the resident with changing her clothes. The resident leaned to one side, then hit her head on the bedrail and fell to the ground. FM4 reported R15 requires two staff for assistance because the resident is dependent on staff and cannot do things for herself. As a result of the fall, R15 needed stitches to the forehead, fractured some bones in her neck, and was not quite the same after the fall. Asked FM4 for an example of how the resident was not the same after the fall. FM4 stated, prior to the fall R15 would speak and have conversations with FM4 during visitations, but since the fall the resident is unable to hold a conversation and when she does answer it's with minimal responses. Conducted a review of R15's Electronic Health Record (EHR) on 06/23/25 at 09:15 AM. Review of Registered Nurse (RN) 3 Statement written on 05/06/25 documented, Per CNA (Certified Nurse Aide (CNA) 9), she assisted resident to sit on the side of bed and tried to put on resident's sweater when resident suddenly tilted on her right side and bump her head on the bed's side rail. CNA lost her grip on the resident and slowly slide her from bed to the floor where resident landed on her left side. CNA yelled for help and other CNA came, and assisted resident to sit up. Other CNA called this writer to assess. Review of the resident's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/21/25 Section GG, Functional Abilities, GG0130, Self-Care documented the resident is dependent (helper does ALL the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for oral hygiene, toileting, shower/bathe, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Review of a progress note, post fall evaluation, written on 05/06/25 at 11:03 AM, Certified Nurse Aide (CNA) was trying to put on R15's sweater while the resident was sitting on the side of the bed, sustained a laceration measuring 2.5 centimeters (cm) with bleeding and a bump with redness measuring 3.5 cm x 4.0 cm. and the resident was sent to the emergency room (ER). Upon returning to the facility (on 05/09/25) from the ER, the resident was diagnosed with a traumatic subdural hemorrhage without loss of consciousness and displaced fracture of the first cervical vertebra. On 06/23/25 at 09:44 AM, conducted an interview with CNA9 regarding R15's fall. CNA9 confirmed R15 is unable to support her trunk while sitting on the side of the bed with both feet on the ground. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	CNA9 stated in that position, R15 will sway and requires support to stabilize the resident as she will sway from side to side. Inquired if in CNA9's opinion, R15's upper body can safely be dressed by one staff while sitting on the side of the bed with both feet on the ground. CNA9 confirmed in that position, R15 requires two staff to assist her, one to put on the upper body clothing and another staff to ensure the resident does not fall. Conducted an interview and record review with the Administrator regarding R15's fall on 06/23/25 at 10:59 PM. Administrator confirmed the investigation process was started as soon as he became aware of the incident and only one CNA was in the room assisting R15 with putting on a sweater while the resident was sitting on the side of the bed with both feet on the ground. On 06/23/25 at 11:23 AM, conducted an interview with CNA8 regarding R15's functional abilities. Asked CNA8 if one staff can put a sweater on R15 without a second staff, safely. CNA8 confirmed while the resident is sitting on the side of the bed, even with both feet on the ground, R15 will sway back and forth. Asked if R15 has the trunk strength to support herself. CNA8 confirmed R15 has poor trunk strength and little to no control of her trunk and needs two staff to safely dress the resident and R15 needs two staff to be able to sit up in bed. On 06/23/25 at 12:10 PM, conducted an interview with CNA Manager (CNAM) 14 regarding R15's fall. During the interview, CNA14 confirmed two staff should have been with the resident while R15 was seated at the side of the bed, putting the resident's sweater on, one staff to support the resident in the seated position and another staff to provide support to the resident. CNA14 pointed out that if R15 was lying in bed, then one staff would be able to safely dress the resident. CNA14 confirmed R15's fall on 05/06/25 was avoidable and the resident sustained physical injuries. While on survey it was determined that the facility corrected this deficient practice. A complete and thorough investigation was conducted by the Administrator in a timely fashion. R15's care plan interventions were updated to ensure the resident was in a stable position prior to staff dressing her upper body. All residents were reviewed and identified for the potential of needing a two-person assist at all times. Staff were re-trained on safe completion of the resident's Activities of Daily Living (ADLs) and training on which residents require two-person assistance. The facility also devised a color-coded system for staff to easily identify which resident required two-person assistance. For example, residents who require two-person assistance have a green name plate outside their room and resident who do not need a two-person assist has a white name plate. The use of the color-coded system for identifying residents in need of two-person assistance was observed on the unit. Interviews with staff documented the color-coded system was a practical and effective intervention. In addition to addressing and reviewing all the current residents, the facility implemented monitoring newly admitted residents for one week, then review their ADLS to determine if the resident is a two-person assist at all times. These corrective actions were implemented into the facility's Performance Improvement program. Monitoring and evaluation of the newly implemented interventions are on-going.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview and record review, the facility failed to communicate food preferences to all staff involved in the preparation and service of resident meals for one resident (Resident (R) 42) sampled for accommodation of food preferences. This deficient practice did not ensure that the resident's food choices were honored. Findings include: On 06/18/25 at 02:23 PM, R42 was interviewed in her room and stated that she does not like and will not drink milk or eat butter and cheese. On 06/19/25 at 02:03 PM, a review of R42's nutrition care plan did not include the resident's preferences of no milk, butter, and cheese. A 05/07/25 Initial Care Plan Meeting note for R42, found in the progress notes of the Electronic Health Record (EHR), stated to allow whole finger food, banana, dessert with no mention of R42's preferences. On 06/19/25 at 04:05 PM, R42 a second interview with R42 was conducted. The resident reiterated that she does not like to eat milk, butter, and cheese. She stated when first admitted to the facility, she was asked about her food preferences and shared her likes and dislikes. On 6/19/25 at 04:13 PM, the top of the dinner meal ticket stated no butter and milk. It did not include, no cheese. On 06/20/25 at 07:05 AM, the breakfast meal ticket also did not include no cheese. On 06/20/25 at 09:48 AM, conducted a concurrent interview with Chef and observation of the lunch meal tray line. Chef confirmed that meal preparation for each resident is based on what is listed on the meal ticket obtained from the Dietician and Dietary Clerk. Therefore, if a resident's preferences are not listed, it will be prepared, plated, and served to the resident. On 06/20/25 at 10:38 AM, the Registered Dietician (RD) 23 was interviewed at her desk with a concurrent review of R42's initial nutritional assessment, dated 05/01/25, located in the EHR. The nutritional assessment stated under 14b. Dislikes a notation of no butter, no cheese, hot drinks. RD23 confirmed that only no butter and milk was listed on the top of the meal ticket for R42. RD23 stated that no cheese was not listed because only a certain number of characters could by typed on the ticket and there was not enough space to put all the information. RD23 then stated that additional dietary information is put in a binder that staff can refer to, the care plan can be checked for resident dietary preferences, and the Health Services Assistant (HSA) 2, who checks the meal trays before it is served, was aware of R42's preferences. When asked how the kitchen staff are aware of a resident's preference when preparing the food, RD23 stated that it is not the kitchen staff's responsibility and if a resident is served something they dislike, the kitchen is called for a substitution. On 06/20/25 at 11:05 AM, HSA2 was interviewed at the meal tray preparation area on the resident unit with RD23 present. HSA2 identified the preference of no milk and butter on RD23's meal ticket but was unaware R42's preference of no cheese. On 06/20/25 at 11:45 AM, RD23 provided the reference binder that contained additional dietary information. RD23 verbalized that resident food preferences were not listed in this binder.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. Based on observation and interview the facility placed oral care supplies (used for mouth hygiene and kept as clean as possible) with incontinent care supplies (used for managing bodily waste) and instant food and beverage thickener packets with adult briefs in the resident bedside storage drawers for two of two residents (Resident (R) 13 and R15) sampled. This deficient practice increases the risk of cross-contamination (potential for microorganisms to transfer from one supply to another) and transfer of microorganisms from the perineal and buttock area to the mouth. Findings include: On 06/20/25 at 08:51 AM, Certified Nurse Aide (CNA) 8 and CNA14 was observed providing bladder and bowel incontinence care for R13. Incontinence care supplies (tube of moisture barrier cream and disposable incontinence wipes) were removed from R13's bedside drawer by CNA14. Bladder and bowel incontinence care was provided to R13 using those supplies. Once completed, the used supplies were returned to the drawer by CNA14. Inspection of R13's drawer with CNA14 observed both incontinence care supplies, including the incontinent care supplies just used by CNA14, and an open package of oral swab sticks were stored in the same drawer with an opportunity for the transfer of microorganisms from the perineal and buttock area to the supplies used in the resident's mouth. CNA14 stated the open package of oral swab sticks (which were not individually wrapped in the package) should not be stored in that drawer because bladder and bowel should not be mixed with oral, and proceeded to remove the package of oral swab sticks. On 06/23/25 at 10:32 AM, the Infection Preventionist (IP) was interviewed. The IP stated best practice is to separate clean and dirty items, however, oral and incontinence care products can be stored together if they are not touching. On 06/23/25 at 10:50 AM, observation of R15's bedside drawer was done with the IP and Certified Nurse Aide Manager (CNAM) 2. Disposable briefs and three packets of instant food and beverage thickener, partially tucked under a brief, were observed stored together. CNAM2 confirmed that the briefs and oral thickener packets should not be stored in the same drawer together and proceeded to remove the thickener packets and disposed of them in the trash receptacle.