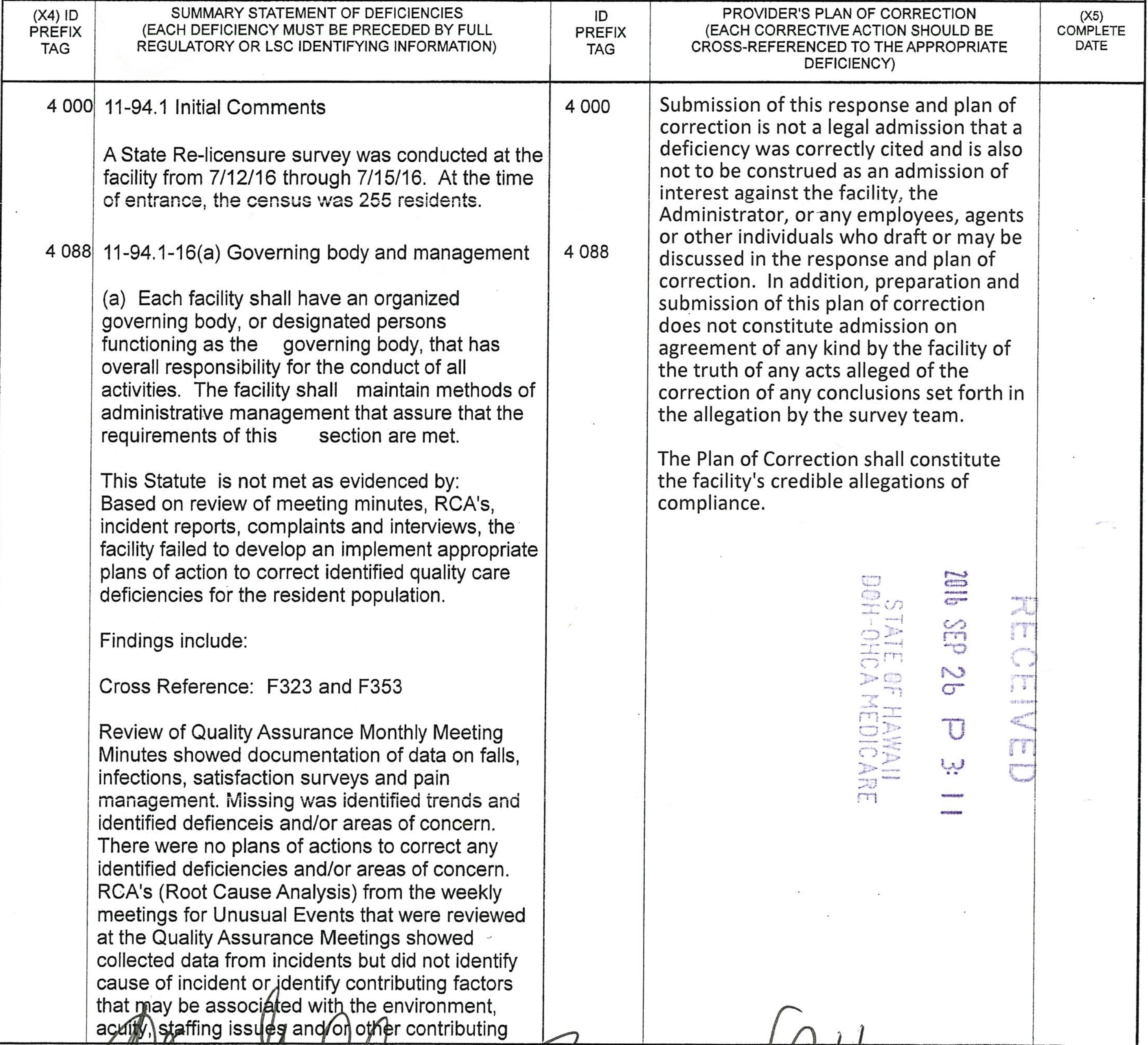
PRINTED: 08/23/2016
FORM APPROVED

Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125011	A. BUILDING: ______ B. WING ______	07/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE NANI REHABILITATION AND NURSING C	1677 PENSACOLA STREET HONOLULU, HI 96822



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4 000	11-94.1 Initial Comments A State Re-licensure survey was conducted at the facility from 7/12/16 through 7/15/16. At the time of entrance, the census was 255 residents.	4 000	Submission of this response and plan of correction is not a legal admission that a deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employees, agents or other individuals who draft or may be discussed in the response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute admission on agreement of any kind by the facility of the truth of any acts alleged of the correction of any conclusions set forth in the allegation by the survey team. The Plan of Correction shall constitute the facility's credible allegations of compliance.	
4 088	11-94.1-16(a) Governing body and management (a) Each facility shall have an organized governing body, or designated persons functioning as the governing body, that has overall responsibility for the conduct of all activities. The facility shall maintain methods of administrative management that assure that the requirements of this section are met. This Statute is not met as evidenced by: Based on review of meeting minutes, RCA's, incident reports, complaints and interviews, the facility failed to develop an implement appropriate plans of action to correct identified quality care deficiencies for the resident population. Findings include: Cross Reference: F323 and F353 Review of Quality Assurance Monthly Meeting Minutes showed documentation of data on falls, infections, satisfaction surveys and pain management. Missing was identified trends and identified defienceis and/or areas of concern. There were no plans of actions to correct any identified deficiencies and/or areas of concern. RCA's (Root Cause Analysis) from the weekly meetings for Unusual Events that were reviewed at the Quality Assurance Meetings showed collected data from incidents but did not identify cause of incident or identify contributing factors that may be associated with the environment, acuity, staffing issues and/or other contributing	4 088		

RECEIVED
2016 SEP 26 P 3: 11
STATE OF HAWAII
DOH-OHCA MEDICARE

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Regional VP Hawaii (X6) DATE 9/13/2016

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Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 9/8/2016

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4 088	Continued From page 1 factors and/or occurrences occurring at the time of the event. There was no documentation that information or data from the weekly Unusual Events meetings was reviewed in the monthly Quality Assurance Meetings nor was there any documentation to reflect appropriate plans of action were developed and implemented. With this number of injuries from falls, the facility should have identified falls as an area of high concern in Quality Assurance Monthly Meetings where active appropriate plans of action were developed, implemented and outcomes assessed. There was no documentation that this had occurred. Interview with members of the Quality Assurance Team, verified that these processes were not occurring in the Quality Assurance Meetings.	4 088	1) No affected residents identified. 2) All residents have the potential to be affected. 3) Regional Nurse Consultant educated QAPI Committee Members on 8/24/16 regarding the need to identify issues which require quality improvement and to develop and implement appropriate action plans to correct identified issues. Quality Measures and Clinical Metrics Report will be used to identify care areas which are trending negatively regardless of percentile. 4) QAPI Committee will utilize QAPI resources from Mountain Pacific QIO to improve and build on current process. A schedule of completion for QIO QAPI webinars will be maintained and audited quarterly. 5) Compliance will be achieved by 8/29/16 and ongoing.	8/29/16
4 115	11-94.1-27(4) 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: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility;	4 115		

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4 115	Continued From page 2 This Statute is not met as evidenced by: Based on resident and staff interviews the facility failed to promote care for one residents in the Stage II survey sample in a manner that maintained or enhanced dignity and respect in full recognition of individuality by failure to respond in a timely manner to requests for assistance while using the rest room. Findings include:	4 115	2) All residents have the potential to be affected. Call light response times will be audited with emphasis on evenings and nights to identify other residents who may have to wait extended periods for assistance. 3) DON/Designee educated nursing staff on 8/30/16 ensuring that residents have the proper means to call the staff, the timely answering of call lights and that call lights are placed within reach based on resident's medical condition and as indicated in the plan of care.	8/29/16

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4 115	Continued From page 3 In an interview with the Director of Nursing (DON) at 3:15 p.m. on 7/14/16, stated that they "usually schedule 3 CNA's and 1 LN for 50 residents on the Piikoi 1 and 2 units". stated that only 1 staff member took a break at a time and that 3 staff were on the unit to care for the residents at night. stated that they were "promised two more float staff for the facility on evening and night shifts which will cover all 5 units".	4 115	4) Audits will be conducted 3x per week x 2 weeks, 2x per week x 2 weeks, then weekly x 4 weeks on varying floors and at various times to monitor call light response times. Audits will also be conducted by the DON/Designee to visualize compliance of call light placement. Audits to include 3 to 5 residents per week per floor x 4 weeks, and then 3 to 5 residents per week x 2 months. Weekly Leadership Rounds will be done and in-service "huddles" will be given if similar concerns are identified. DON/Designee will report findings from both audits to Quality Assurance and Performance Improvement (QAPI) Committee for further resolution and recommendation. 5) Compliance will be achieved by 8/29/16 and ongoing.	

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4 115	Continued From page 4	4 115		

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4 115	Continued From page 6	4 115		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth.	4 136		

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4 136	Continued From page 7 This Statute is not met as evidenced by: Based on review of a complaint, event reports, policies and procedures and QA reports, the facility failed to ensure the environment was free from accident hazards over which the facility had control, and provided adequate supervision and assuasive devices to each resident to prevent avoidable accidents. This included identifying hazards and risks; evaluating and analyzing hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary for 2 out of 42 stage 2 residents. Cross Reference F353 and F520	4 136	2) Residents who fall have the potential to be affected. All residents with falls in the past 30 days will be reviewed for causal factors and re-assessed for appropriateness of the fall intervention and update care plan. 3) Staff educated by DON/Designee on 8/30/16 regarding the need to identify factors that place residents at risk of falling. Also reviewed were the need to add appropriate interventions to the care plan and the process for determining the root cause of the fall timely and adding new interventions to prevent Further falls and/or in ury. We will institute Fall Huddles for residents who have fallen utilizing the Fall Scene Investigation Tool as a guideline. In addition, residents with falls will be reviewed during morning staff meeting. The IDT members will start assessing for the causal factors and ensure intervention is in place and care plan is updated. The Unusual Occurrence Committee will meet weekly and further discuss the cause of each fall and re-evaluate any previous interventions to address fall. 4) DON/Designee will conduct audits of unusual occurrences weekly to assure plan of care updated with appropriate new interventions. Residents who have a fall will be monitored x 30 days to evaluate that interventions have addressed the cause of the fall. DON/Designee will report findings to QAPI Committee for further resolution and recommendation. 5) Compliance will be achieved by 8/29/16 and ongoing.	8/29/16

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4 136	Continued From page 8	4 136		

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4 136	Continued From page 10	4 136		

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4 136	Continued From page 12	4 136		
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on resident and staff interiews, along with record reviews, the facility failed to ensure there was sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Findings include: Cross Reference: F353 1) The resident reported that during the night shift there are not enough staff available to assist residents. 2)	4 148	2) All residents have the potential to be affected. 3) DON/Designee educated Licensed Staff on 8/30/16 regarding the need to answer call lights timely, anticipate needs, prioritize, and consolidate care. A CNA Float Pool is being developed to provide a resource to cover staff call-offs. 4) DON/Designee will conduct audits on call light response times 3x per week x 2 weeks, 2x per week x 2 weeks, then weekly x 4 weeks on varying floors at varying times. In addition, audit of staffing levels will be done weekly x 12 weeks to monitor staffing and identify areas of need. DON/Designee will report findings to QAPI Committee for further resolution and recommendation. 5) Compliance will be achieved by 8/29/16 and ongoing.	8/29/16

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4 148	Continued From page 13	4 148		

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4 148	Continued From page 14	4 148		

In a record review of the staffin g schedule on 7/14/16 at 11:08 A.M., for a period of 2 weeks, the staffing showed that the regular schedule on Piikoi 1 and 2 have the following: Day = 6 CNA + 2 LN; Evening = 4 CNA + 1 LN; and Nights = 3 CNA + 1 LN

The following staffing for a period of 3 days over a weekend shows less staff than regular scheduling

* Based on notes from Resident Counsel meetings the residents pointed out that there are less staff on evenings when dining and when residents need assistance to get into bed and toilet. Evening and night shift are the times they feel that there isn't enough staff to assist without keeping residents waiting.

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4 148	Continued From page 15 The following dates/shifts show staffing that deviated from regular for the Piikoi units. 7/09/16 PII 2. (D) = REG (E) = 3 CNA + 1 RN (N) = REG 7/10/16 PII 1 (D) = REG (E) = 2 CNA +1 RN (N) = REG PII 2. (D) = REG (E) = 2 CNA = 2 until 9:30 + 1 RN (N) = REG 7/11//16 PII 2. (D) = REG (E) = 4 CNA + 0 RN (N) = REG 7/13/16 PII 2. (D) = 5 CNA + 2 RN (E) = REG (N) = 3 CNA + 0 RN In an interview with the Director of Nursing (DON) at 3:15 P.M. on 7/14/16 regarding sufficient staffing, stated that at night they usually have 3 CNA's on that unit and 1 nurse for 50 residents. stated that only 1 staff member would take a break at a time and that the remaining 3 staff care for the residents. stated that they were "promised 2 more float staff for the facility on evening and night shift which will cover all 5 units".	4 148		
4 174	11-94.1-43(b) Interdisciplinary care process (b) An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social	4 174		

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4 174	Continued From page 16 work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education. This Statute is not met as evidenced by: Based on record review the facility failed to develop comprehensive care plan of care for 2 out 42 stage 2 residents. Findings include:	4 174	1.1) Care plan for the resident with the order of was updated on 7/14/16 by the UM and includes monitoring of side effects. 2) Residents on medications that require monitoring for specific side effects have the potential to be affected. Residents receiving will be reviewed by DON/Designee to ensure care plan reflects current orders. 3) DON/Designee educated Licensed Staff on 8/30/16 regarding the need to develop care plans that monitor potential side effects. The Admission Nurse will add in the care plan monitoring of side effects when indicated upon admission or with new orders, and the UM will review within 48 hours. 4) DON/Designee will conduct audits on 5 residents per week x 4 weeks, then 5 resident per month x 2 months to validate that residents with black box warning medication have a care plan in place. DON/Designee will report findings to QAPI Committee for further resolution and recommendation. 5) Compliance will be achieved by 8/29/16 and ongoing.	**8/29/16**
4 175	11-94.1-43(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 observation, interviews, and record	4 175		

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4 175	Continued From page 17 review, the facility failed to provide the necessary care and services for the resident to maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and pan of care for 2 residents of the 42 in the Stage 2 sample. Findings include:	4 175	2) All residents have the potential to be affected. 3) DON/Designee educated Licensed Staff on 8/30/16 regarding the need to ensure that care plans are accurate and updated on the current status of the residents. The Admission Nurse will add monitoring on the TAR and care plan upon admission and with any new placement. The UM will validate the TAR and care plan within 48 hours. 4) DON/Designee will utilize a tracking log to identify residents with a new behavior x 2 months to validate that care plans for residents with new behaviors are in place. Audit will be done of residents with AV fistulas/ shunts x 1 to assure monitoring of patency is being done. 3 to 5 new residents admitted with an AV shunt/ fistula will be audited per month x 2 months to validate compliance has been sustained. DON/Designee will report findings to QAPI Committee for further resolution and recommendation. 5) Compliance will be achieved by 8/29/16 and ongoing.	8/29/16

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4 175	Continued From page 18 Interview on 07/13/16 at 2:50 PM interview with LN#3 was unable to show any monitoring or documentation for AV fistula in their careplan, treatment record or monitor record. When asked "where do you document and record your assessment for AV fistula"? LN#3 stated "It should be in the treatment record (TAR) or monitor record and there is no care plan but it's supposed to be".	4 175		

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4 175	Continued From page 19 Interview on 07/13/16 at 0300 PM Interview with Unit Manager "It is supposed to be there" but it's not. I am going to correct this". In conclusion, there was no documentation or monitor record in the facility that the above order to monitor and document AV fistula was being completed.	4 175		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observation, staff interview, and review of disinfectant instructions for use, the facility did not maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Findings include: 1) Observation was made on Pensacola II on 7/15/16 at 9:05 AM of a Certified Nurse Aide (CNA) cleaning a shower chair after resident use. Staff obtained a spray bottle out of a locked cabinet in the shower room. The label on the container read "DMQ disinfectant -- damp mop neutral disinfectant cleanser". Directions for use	4 203	1.1) Nursing and Housekeeping staff were in-serviced on disinfecting shower chairs with the use of the DMQ solution, storage and replacement of solution on 7/15/16. 1.2) Licensed Nurse #5 and Speech Therapist were re-educated on hand washing policy and procedure on 7/15/16. 1.3) Licensed Nurse #5 was educated by UM on 7/15/16 regarding the importance of disinfecting the glucose machine after every use and ensure the manufacturer's instructions for wet/dry times are followed. 2) All residents have the potential to be affected. 3) ADON/Designee re-educated staff on 8/30/16 on proper hand washing technique, disinfecting shower chairs, disinfecting glucose machine, disinfecting chemicals presently being used at the facility and safe storage of these chemicals. will be disinfected according to product instructions after each use by CNA.	8/29/16

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4 203	Continued From page 20 on the bottle noted "follow disinfectant for use on pesticide container". There was no label on the spray bottle to indicate when it was mixed. Staff was not sure how to use the disinfectant as there was no instructions for use. Observed staff proceed to spray the seat of the shower chair with the disinfectant then immediately wiped the seat with a paper towel. Staff discarded the paper towel and sprayed a clean paper towel with disinfectant and wiped the seat of the shower chair again. discarded the paper towel and sprayed clean paper towels with the disinfectant to wipe down the bars of the shower chair. No observation was made of disinfection under the seat of the shower chair. Staff then said completed the task and parked the shower chair in the shower stall. Interview with the Unit Manager (UM) was done on 7/15/16 at 9:20 AM regarding the facility's policy on cleaning shower chairs after resident use. The UM retrieved the DMQ solution from the shower room. acknowledged there was no directions for use on the bottle. The UM stated staff should be washing the shower chair with water first, then spray DMQ solution over the shower chair, and wait 30 minutes before using. Interview and concurrent review of the DMQ product information was done with the Assistant Director of Nursing (ADON) on 7/15/16 at 11:10 AM The ADON stated that for "cleaning, sanitizing and deodorizing hard non-porous surfaces: use DMQ at 2 oz. per gallon of water. Apply with a mop, cloth or coarse spray device. Treated surface must remain wet for 30 seconds. Wipe off with a clean cloth or allow to air dry". It was also noted to "prepare fresh solution daily..." The ADON acknowledged there was no directions for use on the DMQ container and there was no	4 203	4) Audits will be done to assure competency of hand-washing technique for all staff by ADON/Designee, to be completed by 10/31/16. Audit will be done to monitor disinfecting of glucometer after use by DON/Designee of 5 to 10 nurses per week until all have been audited with a competent performance. 5 to 15 CNAs will be audited per week by DON/Designee for competence in cleaning shower chair after use until all CNA staff have been observed. DON/Designee will report findings to QAPI Committee for further resolution and recommendation. 5) Compliance will be achieved by 8/29/16 and ongoing.	

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4 203	Continued From page 21 date on the container to indicate when it was mixed. 3) Dining observation on Lewalani Ground on 07/12/16 at 11:50 AM A speech therapist (ST) hurriedly entered the dining area without observation of hand sanitization or handwashing. ST walked over to a resident's table across from this surveyor and grabbed salt and pepper for a resident. When leaving the table, The ST rubbed both hands in a downward fashion on clothing. then walked over to the food cart where the trays were and grabbed another resident's tray. At that point, this surveyor approached the ST and asked "have you performed any type of hand sanitization or handwashing?" The ST immediately passed the tray in hands over to a staff member standing at food cart. ST apologized profusely and went to wash hands. After ST washed hands,	4 203		

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4 203	Continued From page 22 apologized again that did not wash hands. 4) Observation was done on Lewalani 1 on 07/14/2016 at 1100 AM with LN#4 of an Accucheck testing and machine cleaning. The blood sugar machine was taken out of a black bag by LN#4. The glucose testing equipment were prepped on a drape on cart. The drape with equipment was then carried to the resident's table. LN#4 washed hands. LN#4 placed clean gloves. The accucheck machine was placed on nursing cart. LN#4 used Sanicloth to wipe down machine the accucheck machine. After 30 seconds, LN#4 placed the accucheck machine back in the black bag. LN#4 was asked what the contact time is for Sani-Wipe. LN#4 stated it is 3 minutes. On further questioning, surveyor asked "How long did you wait after you wiped it down"? LN#4 stated "Oh it was not long enough" acknowledging did not wait three minutes. LN#4 then stated that would do better next time. Interview was done on Lewalani Ground with Clinical nursing assistant (CNA#2) on 07/14/16 at 10:09 AM The question was posed to CNA#2 in the shower room on Lewalani Ground. "How do you clean your shower chairs"? CNA#2 stated "usually housekeeping takes the chairs outside and cleans it in the morning and evening". "How do you clean shower chairs in between residents?" "I usually shoot it down with hot water". There are three shower chairs, one in room 9 and one in shower room and in room 3. Interview with Housekeeping (HK) on 07/14/2016 at 1030 AM HK was asked "Tell me how you clean the shower chairs?" HK stated " I use a bleach. Staff obtained a bottle from cart	4 203		

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4 203	Continued From page 23 labeled Diffense. The label on the bottle read "Diffense". There were three manufacture directions for contact times which were 30 seconds, 60 seconds and eight minutes respectively. Eight minutes for bacterial/viral sporacidal cleaning. HK was further asked about contact time. HK was puzzled. These directions were shown to HK. HK stated cleans the chairs 2x/day in the am and afternoon. HK was not aware of the different contact times or of the directions on the bottle and was not able to elaborate on the difference between the contact times. Interview and concurrent review of hand washing, cleaning of equipment (shower chairs and accucheck machine) was done with the ADON on 07/15/16 at 10:10 AM ADON was told about dining observations made on Lewalani Ground on 07/12/16 at 11:50 AM when ST did not perform hand sanitization or hand washing. ADON acknowledged that ST should have washed hands before and after assisting a resident with meals. The ADON was then told about observation made on Lewalani 1 on 7/14/2016 at 11:00 AM with LN#4 ADON was told of LN#4 did not adhere to the correct contact time on the Saniwipe label when cleaning the Accucheck machine. ADON stated that will have to tighten up and do inservices regarding accuchecks, shower chairs, contact times with new product and product use. ADON was asked regarding infection control for shower chairs. They are supposed to spray it down with DMQ. DMQ is new and being rolled out right now. Surveyor asked "how did you inservice them regarding DMQ?" "I have to check on this" ADON stated. ADON was informed about a knowledge deficit with CNAs and housekeeping when it related to contact	4 203		

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4 203	Continued From page 24 times and chemical application for infection control. ADON was informed regarding deficiency with cleaning of shower chairs between resident-to-resident use and acknowledged that will have to tighten up inservices in this area. Review of policy and procedure for hand hygiene from ADON which states: Hand hygiene is the primary means of preventing the transmission of infection. Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections. Alcohol based hand rubs will not be used in place of proper hand washing techniques in a food service setting. Considerations: 5. Before and after assisting a resident with meals (hand washing with soap and water).	4 203		
4 270	11-94.1-65(d)(7) Construction requirements (d) The facility shall have adequate toilet and bath facilities: (7) Each toilet and bath facility shall have a call system that permits the occupant to signal the nursing station in an emergency; This Statute is not met as evidenced by: Based on observation and interviews the facility failed to equip resident calls through a communication system from the resident toilet for 2 residents in the survey sample. Findings include: 1) On 7/12/16 at 10:59 AM during a check of the call light in bathroom shared by found that the bathroom call light next to the toilet would not activate when pulled. LN#2 was	4 270		

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4 270	Continued From page 25 called into the room and was not able to activate the call light at first. LN #2 then pulled the shower chord hanging against the wall across from the toilet and then pulled the call light next to the toilet causing the toilet light to light up and alarm. LN #2 said a work order would be placed to maintenance to have the call light checked. 2) On 7/12/16 at 2:55 PM the call light in the bathroom was found hanging on the	4 270	1.1) Call lights for were repaired on 7/15/16 and are in working order. 1.2) Call lights for is functional after plastic bag was removed on 7/12/16. 2) All residents have the potential to be affected. All call lights to be audited x 1 for proper function. 3) Staff were educated on 8/30/16 by Administrator/Designee regarding the need to promptly report and repair any malfunctioning call light. Switchboard Operator will maintain a log of all maintenance work order calls that are made to the Operator. 4) Weekly Leadership Rounds Report, which includes monitoring of call light function, will be reviewed by Administrator/Designee and findings will be reported to QAPI Committee for further resolution and recommendation. 5) Compliance will be achieved by 8/29/16 and ongoing.	8/29/16

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4 270	Continued From page 26 safety rail next to the toilet with a plastic bag tied to the end of the pull chord. When pulled the call light would not alarm. LN #3 was called to the room and the pull chord with the trash bag attached was pointed out. LN #3 pulled the chord and it would not activate, LN #3 then untied the plastic bag to let the chord hand, then pulled the chord and the call light alarmed.	4 270		
4 280	11-94.1-65(e)(7) Construction requirements (e) The facility shall have resident bedrooms that ensure the health and safety of residents: (7) Beds shall be placed at least three feet apart; and This Statute is not met as evidenced by: Based on the room observations and interview with the Administrator, the facility did not ensure that bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms. Findings include: During the entrance conference, the DON stated there have been no construction or structural changes to the rooms on the Pensacola 1 and 2 wings for the 18 rooms with the room waivers. On 7/12/16, the DON provided a list of the residents residing in the 18 bedrooms requiring a variance as these rooms do not meet the square footage requirement for residents residing in multiple resident bedrooms. On 7/15/16 at 9.50 AM, interview with the Administrator revealed intent is to reduce the	4 280		

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4 280	Continued From page 27 variance from 18 to 12 by constructing 3 more semi-private rooms." stated, "Currently construction is held up by waiting for construction permits. Permit was currently been held up in the Waste Water Department for the last 3 months." Once permit is approved in the Waste Water Department they will be able to proceed in putting it out for bids. is hoping once a building contractor is selected for project that the construction will be completed within six months. The following 18 resident rooms that do not meet the square footage requirement are as: Pensacola 1 wing: Room 102 for 3 residents = 215 sq. ft. Room 103 for 3 residents = 213 sq. ft. Room 106 for 3 residents = 214 sq. ft. Room 107 for 3 residents = 213 sq. ft. Room 110 for 3 residents = 215 sq. ft. Room 111 for 4 residents = 273 sq. ft. Room 112 for 3 residents = 210 sq. ft. Room 113 for 4 residents = 270 sq. ft. Room 116 for 3 residents = 213 sq. ft. Room 117 for 3 residents = 215 sq. ft. Pensacola 2 wing; Room 202 for 3 residents = 212 sq. ft. Room 203 for 3 residents = 213 sq. ft. Room 206 for 3 residents = 213 sq. ft. Room 207 for 3 residents = 212 sq. ft. Room 211 for 3 residents = 213 sq. ft. Room 214 for 3 residents = 213 sq. ft. Room 215 for 3 residents = 213 sq. ft. Room 218 for 3 residents = 213 sq. ft. The Administrator also provided a detailed explanation and letter with architectural design plans to eventually decrease the number of waivers with the impending future construction of	4 280	1) The Administrator requested a waiver from the Office of Health Assurance Medicare Certification. The following (18) resident rooms do not meet the 80 square feet requirements: Pensacola 1 Wing - RM #102 for 3 residents = 234.78 Sq. Ft. RM #103 for 3 residents = 235.94 Sq. Ft. RM #106 for 3 residents = 235.34 Sq. Ft. RM #107 for 3 residents = 236.59 Sq. Ft. RM #110 for 3 residents = 237.14 Sq. Ft. RM #111 for 4 residents = 294.74 Sq. Ft. RM #112 for 3 residents = 232.86 Sq. Ft. RM #113 for 4 residents = 292.44 Sq. Ft. RM #116 for 3 residents = 236.5 Sq. Ft. RM #117 for 3 residents = 234.5 Sq. Ft. Pensacola 2 Wing - RM #202 for 3 residents = 225.69 Sq. Ft. RM #203 for 3 residents = 227.4 Sq. Ft. RM #206 for 3 residents = 221.13 Sq. Ft. RM #207 for 3 residents = 230.42 Sq. Ft. RM #211 for 3 residents = 230.22 Sq. Ft. RM #214 for 3 residents = 225.69 Sq. Ft. RM #215 for 3 residents = 223.84 Sq. Ft. RM #218 for 3 residents = 224.04 Sq. Ft. 2) Other residents' rooms throughout the facility were measured with no deficiency noted. 3) The Administrator has requested a new waiver from the Office of Health Care Assurance on 9/1/16. 4) Continue to follow new waiver request from the Office of Health Care Assurance annually. 5) Plan of Correction will be accomplished by 8/29/16 and ongoing.	8/29/16

Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125011	A. BUILDING: ______ B. WING ______	07/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE NANI REHABILITATION AND NURSING C	1677 PENSACOLA STREET HONOLULU, HI 96822

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4 280	Continued From page 28 3 additional semi-private rooms. The administrator also provided an email in regards to the permit hold up in the Waste Water Branch of Approvals. In the interim, the Administrator requested the longstanding room variances be reviewed for the now 18 rooms with the intent to eventually decrease it to 12 rooms needing a variance.	4 280		