STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 05/12/25-05/15/25. The facility was not in compliance with 42 CFR 483 Subpart B. Survey Census: 255 Sample Size: 63	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

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

Electronically Signed

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: 3) On 05/12/25 at 12:54 PM observed CNA11 assist R56 with her lunch. CNA11 was observed standing up while assisting R56. CNA11 uncovered R56's food, mixed some of the food together and took a spoonful and offered it to R56 as she stood near R56. Right afterwards CNA11 left R56 and went into room 117 and retrieved a meal tray and placed it in the cart. CNA11 returned to R56, stirred her food some more, took another spoonful and offered it to the resident which she took. CNA11 continued to stand near resident during this time. CNA11 left R56 and walked down the hall to another resident and pushed the resident down the hall past R56 to help move him out of the way while a delivery was coming down the same hallway. CNA11 returned to R56, and proceeded to assist R56 with her lunch again by offering her more spoonful of food. At this time the facility Administrator in training appeared with a stool for CNA11 to sit on and he asked her to sit down and stay with R56 while she assisted her with her meal. On 05/12/25 at 02:00 PM interviewed DON in her office. Inquired of DON if staff who are assisting	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 550	Continued From page 2 residents with their meals are to sit and she confirmed this, stated she heard of this and has already done corrective training with the staff. Based on observations and interviews, the facility failed to promote care for residents in a manner that maintains the dignity for three out of three residents Resident (R)330, R331, R56 observed during dining observation. This deficient practice has the potential to affect all residents that require assistance with their meals. Findings include: 1) On 05/12/25 at 08:20 AM, observed Certified Nurse Assistant (CNA)1 assisting R330 with breakfast. CNA1 was standing over R330 instead of sitting down next to her. CNA1 was also conversing with Restorative Nurse Aide (RNA)1 about work and not paying close attention to R330. Concurrent interview with CNA1 completed. CNA1 confirmed that she should be sitting down next to R330 to make her more comfortable and should be more attentive to R330 while assisting her with her breakfast. 2) On 05/12/25/ at 12:41 PM, observed CNA2 assisting R331 with lunch. CNA2 was standing over R331 instead of sitting down beside her. Concurrent interview with CNA2 confirmed that she should be sitting down beside R331 so she can maintain eye to eye contact. On 05/12/25 at 12:50 PM, interview with Licensed Practical Nurse (LPN)1 completed. When asked what their practice was in assisting residents with	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 550	Continued From page 3 meals, LPN1 stated she did not know, but noted residents should not feel intimidated. On 05/14/25 at 11:45 AM, interview with Director of Nursing (DON) completed. DON confirmed that the facility's practice is for CNAs to be sitting down while assisting the residents with their meals, so residents can see the CNA at eye level and communicate with them better.	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-	F 553		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 553	Continued From page 4	F 553		

(i) Facilitate the inclusion of the resident and/or resident representative.
(ii) Include an assessment of the resident's strengths and needs.
(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to facilitate the inclusion of the resident's representative in the resident's care planning for 2 of 5 residents Resident (R) 203 and 532. As a result of this deficient practice, the resident's representative was not able to support and provide input on the resident's goals, choices and preferences.

Findings include:

1) R203 is a 93-year-old male, admitted to the facility on 02/10/24. A Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/13/25 noted that R203 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated that R203 has severe cognitive impairment.

On 05/12/25 at 02:48 PM, interviewed R203's family representative (FR) 10, over the phone, who was listed as R203's responsible party on the facility's admission record. FR10 stated that the care planning meetings for R203 is sporadic and formal meetings are not conducted.

On 05/13/25 at 08:53 AM, interviewed the Minimum Data Set Nurse (MDS) 1 in her office along with a concurrent review of the Electronic Health Record (EHR). MDS1 stated that resident care planning meetings are held quarterly. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 5	F 553		

last care planning meeting for R203 was on 12/03/24 and the next quarterly meeting should have been held in March 2025 and was missed.

On 05/13/25 at 01:39 PM, interviewed the Social Services Director (SSD) at the Social Services office. SSD stated that the Social Services department receives a weekly list of residents due for care planning meeting from the MDS office and schedules the care planning meetings for the following week. SSD did a search in the EHR and confirmed that the last care planning meetingfor R203 was held on 12/03/24 and the next required quarterly care planning meeting was not conducted.

2) On 05/12/25 at 08:52 AM, observed R532 seated in the doorway of the resident's assigned room. R532 was observed wearing brown sweatpants and a black shirt with food stains and urine stains (observed on 05/12/25 at 02:15 PM) starting on Monday, 05/12/25, morning until Tuesday, 05/13/25, at approximately 02:55 PM. R532 was greeted and responded that he wanted to go home. When questioned where home was, R532 stated, "I don't know." R532 was questioned regarding person, place, time, and situation. R532 was able to tell me his name, but no unable to correctly answer on the place, time, or situation. R532 started mumbling about wanting to go home and the interview was terminated.

On 05/12/25 at 11:47 AM, conducted an interview with R532's Resident Representative (RR) 4. RR4 reported R532 has Dementia and at this time is unable to make meaningful decisions for himself. Asked RR4 to give an example of a decision the resident is unable to make. RR4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 6	F 553		

stated R532 is focused on and intends to return home. However, R532 is currently homeless and does not have a safe place to be discharged to. RR4 confirmed the resident can make decisions on day-to-day decisions such as what he wants to eat or use the restroom but is unable to make "big" decisions. Inquired if RR4 received an invitation to R532's care plan meeting or attended a care plan meeting. RR4 confirmed he/she was not invited to participate in R532's care plan meeting and would have attended had RR4 known about it.

On 05/14/25 at 08:16 AM, reviewed R532's EHR. R532's admission MDS with an ARD of 04/24/25, Section C. Brief interview for Mental status score was 5, indicating severe cognitive impairment.

On 05/14/25 at 02:05 PM, conducted an interview with Certified Nurse Aide (CNA) 91, Registered Nurse (RN) 23 and RN41 regarding their interactions with R532 and assessment of the resident. CNA91 reported R532 has been combative and impulsive, for example, he is constantly getting up and walking around trying to go home, he does what he wants when he wants, is refusing care, and has been known to be combative. RN23 and RN41 confirmed what CNA91 reported and added that R532's physician is work with the resident's medications to stabilize the resident. RN23 and RN41 confirmed R532 is unable to make important decisions and is alert and oriented to person.

On 05/15/25 at 09:05 AM, observed R532 seated in a chair near his assigned room, with CNA67. Inquired with CNA67 about what his/her assignment was and reported, being R532's one to one staff. R532 is wandering, is unsteady on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 7 his feet, and can be combative/aggressive. On 05/15/25 at 08:12 AM, reviewed R532's EHR. Review of the facility's Interdisciplinary Team (IDT) Care Plan Conference with Welcome Meeting Form, dated 04/21/2025 10:15 AM and "Section Status: Errors view errors". The only portion of the form filled out as reviewed and discussed was "Activity Participation" with comments, "Resident prefers to participate in independent activities such as watching his bedside TV (television). Resident religion is Catholic". Reviewed the signature page for the IDT baseline care plan meeting (also known as the welcome meeting) and R532 was listed in attendance as "Self- RP" (dated 04/23/25). On 05/15/25 at 09:10 AM, conducted a concurrent interview and review of R532's EHR with Assistant Director of Nursing (ADON) 66 regarding R532's care plan meeting and requested documentation of RR4's invitation and/or attendance of R532's care plan meeting. Reviewed the IDT Care Plan Conference with Welcome Meeting Form and confirmed the document was as this surveyor viewed, with only the activity participation marked and with comments listed above regarding activity preference to watch his bedside TV. ADON66 also confirmed the baseline care plan form with staff and R532's signatures correlated to the IDT Care Plan Conference with Welcome meeting form. ADON66 confirmed RR4 did not attend R532's care plan conference or welcome meeting. ADON66 stated an Admission Staff (AS) 8 is responsible for keeping track of family notification/invitation to the care plan meetings. On 05/15/25 at 10:18 AM, conducted an interview	F 553		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 553	Continued From page 8 with AS8. Requested documentation of RR4's notification/invitation to R532's care plan meeting on 04/21/25 and an acceptance or declination of the notification/invitation. AS8 reviewed her records and confirmed she did not have any documentation because the meeting occurred prior to the facility tracking this information.	F 553		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 36 residents Resident (R)9 in the sample had been determined clinically appropriate to self-administer her medications before leaving them at the bedside for her to take independently. This deficient practice placed R9 at risk of adverse effects related to unsafe medication administration practices. Findings include: R9 is an 89-year-old female admitted on 04/25/23 for long-term care. Review of R9's Minimum Data Set (MDS) Annual Assessment with an Assessment Reference Date (ARD) of 03/31/25 revealed that staff had determined her "Cognitive Skills for Daily Decision Making" were "Moderately impaired - decisions poor, cues/supervision required." On 05/12/25 at 08:52 AM, observation made	F 554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 9	F 554		

while at the bedside of R9. Observed at least six different medications (tablets and capsules) at the edge of the bedside table in front of her. Attempted to ask R9 about the medications but she did not respond verbally to questions, only smiled.

On 05/12/25 at 08:54 AM, called Registered Nurse (RN)3 into the room for a concurrent interview and observation. RN3 confirmed that the medications on the bedside table appeared to be R9's morning medications. RN3 explained that her shift began at 07:00 AM, and when she arrived on the unit, RN5 (a night shift nurse) informed her that he had already administered morning medications to R9. RN3 confirmed that medications should not be left at the bedside.

On 05/12/25 at 09:04 AM, an interview was done with RN5. When asked about leaving the medications for R9, RN5 explained that he was working an extra shift this morning, as he should have completed his shift at 07:00 AM, and he was trying to get a head start on his duties for the morning, so he gave several of the residents their morning medications early. RN5 confirmed he should not have left any medications at the bedside.

On 05/12/25 at 03:05 PM, a phone interview was done with R9's Family Representative (FR)1. FR1 stated that she and her husband have seen medications left on R9's bedside table for her to "take later" on more than one visit.

Review of R9's electronic health record (EHR) noted no assessments done to determine if R9 could be responsible to safely self-administer her medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 10 On 05/15/25 at 07:27 AM, an interview was done with the Director of Nursing (DON) in her office. During a concurrent review of R9's EHR, DON confirmed R9 did not have an assessment documented for self-administration of medications, and with a determination of moderately impaired cognitive skills, she would not be clinically appropriate for this responsibility. The facility's policy and procedure regarding Self-Administration of Medications was requested but not received prior to exit.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to honor the shower preferences of 1 of 2 residents Resident (R)9 sampled for accommodation of needs by having a shower gurney available. In addition, the facility failed to ensure the continuous availability of a mechanical lift for the transfer of the 9 of 40 residents on the floor who require it. As a result of these deficient practices, R9 did not have her needs met and was placed at risk of not attaining her highest practicable well-being. Findings include: R9 is an 89-year-old female admitted on 04/25/23	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 11	F 558		

for long-term care. Review of R9's Minimum Data Set (MDS) Annual Assessment with an Assessment Reference Date (ARD) of 03/31/25 revealed that R9 is fully dependent on staff for transferring in/out of bed and moving from a sitting to a lying position and vice versa. While in bed, R9 needs maximal assistance (staff do more than half the effort) to roll from side to side.

On 05/12/25 at 03:05 PM, a phone interview was done with R9's Family Representative (FR)1. FR1 stated that R9 would like to "shower at least once a week, but only gets a bed bath." FR1 explained that due to her physical limitations, R9 is a mechanical lift transfer but there is only one of those on the floor. Even when staff do transfer R9 with a mechanical lift, the facility does not have the equipment available so that R9 could be showered.

On 05/15/25 at 09:32 AM, an interview was done with Certified Nurse Aide (CNA)4, who had been working at the facility for more than ten years. CNA4 confirmed that R9 needs a mechanical lift to be transferred in and out of bed. When asked about showers, CNA4 stated that R9 "gets bed baths only." CNA4 explained that R9 cannot bend her knees so when she had been transferred to a shower chair in the past, she kept sliding down and could not be showered in it safely. Observation of the shower chair(s) tried noted they were standard shower chairs that could not recline. Observed in the shower room was one large reclining shower chair. Closer inspection of the reclining shower chair noted that when the back was reclined, the knees came up so that the knees were always in a 90-degree angle. CNA4 agreed because R9 could not bend her knees, the reclining shower chair would not be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 12 comfortable. When asked about a shower gurney for residents who could not sit up, CNA4 responded that there were none on the floor. On 05/15/25 at 09:48 AM, an interview was done with Registered Nurse (RN)3, who also served as the Nurse Supervisor. RN3 confirmed that the floor, with a census of 40 residents, did not have a shower gurney. When asked about mechanical lifts for transfers, RN3 confirmed that there was only one on the floor. After consulting with CNA4, RN3 also confirmed that the floor had nine residents, or 22% of the floor, that required a mechanical lift for transfers. On 05/15/25 at 10:13 AM, another interview was done with CNA4. When asked if one mechanical lift for the nine residents on the floor who needed it was adequate to meet their needs, CNA4 responded no, it was not enough. CNA4 explained that the floor's mechanical lift was also taken to other floors for use at times, leaving them without one. On 05/15/25 at 10:17 AM, an interview with Restorative Nurse Aide (RNA)3 was done. RNA3 confirmed that at times, the one mechanical lift is missing from the floor, and he has to go look for it on other floors and bring it back. On 05/15/25 at 11:26 AM, an interview was done with the Director of Nursing (DON) in her office. DON confirmed that there are zero shower gurneys at the facility, with a census of 255 residents, for residents who want to shower but cannot be safely transferred to, or sit in, a shower chair.	F 558		
F 561 SS=D	Self-Determination	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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F 561	Continued From page 13 CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify and support the shower preference of 1 of 2 residents Resident (R)9 sampled for Self-Determination/Choices. As a result of this deficient practice, R9 did not have her needs met and was hindered from attaining her highest practicable well-being.	F 561		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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F 561	Continued From page 14 Findings include: Cross-reference to F558 Accommodation of Needs. The facility failed to secure the equipment necessary to honor Resident (R)9's shower preferences and meet her needs. R9 is an 89-year-old female admitted on 04/25/23 for long-term care. Review of R9's Minimum Data Set (MDS) Annual Assessment with an Assessment Reference Date (ARD) of 03/31/25 revealed that R9 is fully dependent on staff for toileting and requires maximal assistance (helper does more than half the effort) for showering and personal hygiene. Further review noted that in Section F0400 "Interview for Daily Preferences," the question, "How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?" was marked "Somewhat important." On 05/12/25 at 03:05 PM, a phone interview was done with R9's Family Representative (FR)1. When asked if the facility honors R9's choices, FR1 stated that R9 has expressed, and FR1 has communicated to staff, that R9 would like to "shower at least once a week, but only gets a bed bath." On 05/15/25 at 09:32 AM, an interview was done with Certified Nurse Aide (CNA)4, who had been working at the facility for more than ten years. When asked about R9's shower schedule and preferences, CNA4 showed this Surveyor the posted shower schedule indicating that R9 is offered a bath on Tuesdays and Fridays on the day shift. CNA4 stated she did not know what R9's preferences were, but that R9 "gets bed	F 561		

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F 561	Continued From page 15 baths only." On 05/15/25 at 11:26 AM, an interview was done with the Director of Nursing (DON) in her office. During a concurrent review of R9's shower preferences, DON confirmed that although R9 had indicated it was "somewhat important" to her to choose between a shower and bed bath, the facility had failed to identify and document what that choice would be.	F 561		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the individual financial records of 2 of 3 residents Residents (R)104 and R49 sampled for personal funds were made available to them through quarterly statements. As a result of this deficient practice, the residents were not aware of their current account balances and were not afforded the opportunity to periodically reconcile their accounts.	F 568		

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F 568	Continued From page 16 Findings include: 1) R104 is a 68-year-old male admitted to the facility on 05/03/19 for long-term care. A review of R104's most recent Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/31/25 noted a Brief Interview for Mental Status (BIMS) score of 12 out of 15, reflecting a determination that he falls just short of cognitively intact. The previous two MDS assessments, on 08/18/24 and 12/30/24, both have R104 assessed with a BIMS of 15 out of 15. On 05/12/25 at 10:31 AM, an interview was done with R104 at his bedside. R104 confirmed that the facility holds money for him. When asked if he receives periodic statements, R104 reported that his daughter gets statements regarding his account, but he does not. Review of the facility's undated Patient Trust Policies and Procedures revealed the following: "Quarterly Statements - The facility will provide statements to residents and/or responsible party every quarter ..." On 05/14/25 at 01:36 PM, an interview was done with the Business Office Manager (BOM) in her office. When asked about R104, BOM confirmed that R104 does have a "Trust Account" with the facility and that he is his own responsible person regarding the account. During a review of his account details, BOM reported that statements are sent to his daughter at the "address on file" every three months and confirmed that a copy is not delivered to R104 even though he resides at the facility. When asked what the policy is, BOM initially answered that the policy is "to send it	F 568		

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F 568	Continued From page 17	F 568		

[statements] out to the address on file." Surveyor reminded BOM that the facility was cited for the exact same issue last year. BOM then changed her earlier statement and reported that after last year's citation, the facility now sends the quarterly statement to both the address on file as well as takes a copy up to the resident(s). BOM explained that she prints up the statements every quarter and either a business office assistant or someone from social services will take a copy up to the resident. When asked how they document that a copy was delivered to the resident(s), BOM answered that they do not document it anywhere and do not currently have a tracking system set up to ensure that each resident with a trust account receives their statements. Surveyor explained that R104, who she already agreed is alert and oriented, stated that he does not and has not been receiving statements. BOM acknowledged that she had no evidence to the contrary.

2) R49 is a 71-year-old male admitted to the facility on 11/07/15 for long-term care. A review of R49's most recent MDS assessment with an ARD of 04/17/25 noted a BIMS score of 15 out of 15, reflecting a determination that he is cognitively intact.

On 05/12/25 at 01:24 PM, an interview was done with R49 at his bedside. R49 confirmed that the facility maintains a trust account for him. When asked if he receives periodic statements, R49 answered that he does not receive any account statements without asking for one.

On 05/14/25 at 01:36 PM, an interview was done with BOM in her office. When asked about R49, BOM confirmed that R49 does have a "Trust

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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F 568	Continued From page 18 Account" with the facility and that he is his own responsible person regarding the account. During a review of his account details, BOM reported that statements are sent to his "address on file" every three months. BOM confirmed that the address on file is not the facility, although R49 resides here, and like R104, she had no documentation that a copy of any of his statements were delivered to him.	F 568		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as	F 583		

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F 583	Continued From page 19 provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure that the personal information and clinical records of Resident (R)134 were protected. As a result of this deficient practice, residents are at risk of their health information not remaining private. Findings include: On 05/14/25 09:40 AM, while surveyor was walking down the hallway on Piikoi 1, observed ICARE station #10784 (station where Certified Nurse Assistants (CNA) and Restorative Nurse Aides (RNA) document their tasks and interactions with residents) left open and accessible with R134's information to include code status, allergies, diet, and required treatment monitoring. ICARE station was located near the entrance of the wing where there is heavy traffic of other residents and family entering in and out through that area to get to the lanai. On 05/14/25 at 09:45 AM, interview with Registered Nurse (RN)1 completed. When asked if the ICARE station should be left open, RN1 confirmed that it should be closed and exited out for privacy reasons and to comply with the Health Insurance Portability and Accountability Act (HIPAA).	F 583		

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F 583	Continued From page 20 On 05/14/25 at 09:50 AM, interview with Certified Nurse Assistant (CNA)3 completed. When asked if the ICARE station should be left open, CNA3 stated that he forgot to close it out and it should be closed for privacy reasons. On 05/14/25 at 11:45 AM, interview with Director of Nursing completed (DON). DON confirmed that the ICARE stations should be exited out and closed when the CNAs are done documenting their interaction with the residents to comply with HIPAA. Review of the facility's "Resident Rights Privacy and Confidentiality," dated 03/23, in the "Purpose" section, it notes, "Each resident has the right to privacy and confidentiality of personal and medical records." In the "Guidelines" section, it notes, 2."Personal privacy includes accommodations, medical treatment, ...personal care ..."	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		

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F 584	Continued From page 21 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to provide a clean area inside and outside of two of four Residents (R) 75, 159 sampled for Environment. R75's bed side mats were dirty with black marks and R159 sat underneath a dirty ceiling tile with a large black spot. 1) On 05/12/25 at 08:57 AM observed R75 resident in her room in her bed. R75 has fall mats on both sides of her bed. Closer inspection of fall mats found them to be dirty with black marks.	F 584		

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F 584	Continued From page 22 On 05/14/25 at 05:38 PM observed R75 in her bed. Observation of fall mats on either side of her bed do not appear to have any changes, appears dirty with black marks. On 05/15/25 at 06:12 AM observed R75 in her bed as a CNA provided care for her. At this time noted fall mats on either side of R75's bed continues to be dirty with black marks. On 05/15/25 at 07:27 AM interviewed Housekeeper 25. Inquired of housekeeper 25 when was the last time the floor mats were cleaned. Housekeeper 25 stated she was not sure when they were last washed. Housekeeper 25 confirmed the mats were dirty and stated she would clean them with a brush. 2) On 05/15/25 at 07:51 AM R159 was observed sitting in her wheelchair in the hallway outside of her room. Resident had been seen sitting in this same area everyday of survey. At this time surveyor looked up at the ceiling and almost directly above R159 there was a blackened spot on the ceiling tile. Inquired of Registered Nurse (RN) 30 if she was aware of the dirty ceiling tile and she said no and she has not put in anything to maintenance regarding the ceiling tile. Surveyor showed RN30 the dirty ceiling tile and RN30 asked day shift nurse, RN50, to submit a work order to maintenance. At this time RN30 moved R159 into her room. On 05/15/25 at 07:58 AM Maintenance Assistant (MA) came to the unit and RN30 showed MA the dirty ceiling tile. MA said "ok". On 05/15/25 at 08:22 AM ceiling tile was	F 584		

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F 584	Continued From page 23 replaced. Maintenance Supervisor (MS) stated he thought the damage to the ceiling tile might have been from an "old leak". MS looked at the area above the ceiling tile and could not explain where the leak would have come from. MM stated the dirty ceiling tile was dry.	F 584		
F 628 SS=E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 628		

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F 628	Continued From page 24 (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written	F 628		

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HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

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F 628	Continued From page 25 notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon	F 628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 628	Continued From page 26 as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 628		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 628	Continued From page 27 facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is not met as evidenced by: Based on interviews and record review, for the facility failed to ensure the disharge/transfer form used by the facility included all of the Ombudsman's address or the resident's appeal rights and provide written notification of transfer/discharge to the resident and the resident representative for two of three Residents (R)187 and R166 sampled. Finding include: Review of the facility's "Transfer/Discharge Notice" policy, 7."Before a facility transfers or discharges a resident: a. Notify the resident and	F 628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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F 628	Continued From page 28	F 628		

the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand ...the facility must send a copy of the notice of transfer or discharge to the representative of the Office of the state Long-Term Ombudsman. 9. Content of Notice to include, d. A statement of the resident's appeal rights ...e. The name and address of the Office of the State Long-Term Care Ombudsman ..."

1) On 05/13/25 at 03:25 PM, review of R187's Electronic Health Record (EHR) documented the resident was transferred and discharged to the hospital on 12/16/24 and 05/07/25. Unable to locate a written discharge/transfer notification to the resident/resident representative or Ombudsman for both transfer/discharges.

Request a copy of the written transfer/discharge notification from the Director of Nursing (DON). On 05/15/25 at 09:37 AM, conducted an interview with the Director of Social Activities (DSA). DSA confirmed a written notification was not provided to the resident, resident representative, and Ombudsman. DSA stated that she did not know a written notification of transfer/discharge was supposed to be provided to the resident and/or resident representative and the facility has not been providing the written notification but should have been. Also, reviewed the transfer/discharge written notification form documented it did not include the Ombudsman's address but should have included it.

2) On 05/13/25 at 01:30 PM, record review of R166's EHR completed. R166 had three hospitalizations on 09/24/24, 01/28/25, and 03/27/25. There was no discharge and transfer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 628	Continued From page 29 notification found for all three hospitalizations. On 05/15/25 at10:32 AM, received discharge notice to Ombudsman for 03/28/25 and 09/24/24 that was sent via email from Director of Social Activities (DSA), but DSA could not provide proof that notification was sent to R166's representative. The Discharge Notification Form used by the facility was also missing the Ombudsman's address and appeals right information. Per DSA there was no notification sent for the 01/28/25 transfer to the emergency room (ER) as R166 was not admitted and only stayed overnight for observation. Surveyor informed DSA that the discharge and transfer notification form must be sent for all types of discharges and transfers to both Ombudsman and resident representative. DSA stated that they have not been doing that.	F 628		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.	F 641		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

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F 641	Continued From page 30 §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct an assessment that accurately reflects the status of two Residents (R) 9 and R201 of 36 residents in the sample. As a result of this deficient practice, these residents did not have their needs properly identified or met and were hindered from attaining their highest practicable well-being. Findings include: Cross reference to F689 and F740. 1) R9 is an 89-year-old female admitted on 04/25/23 for long-term care. Review of R9's Minimum Data Set (MDS) Annual Assessment with an Assessment Reference Date (ARD) of 03/31/25 noted the question: "Should Brief Interview for Mental Status [BIMS] be Conducted?" had been marked "No (resident is rarely/never understood)." Further review of the 03/31/25 Annual Assessment revealed that R9 had indicated her "preferred language" was Vietnamese, and indicated "yes" to the question regarding " ... need or want an interpreter to	F 641		

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

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F 641	Continued From page 31	F 641		

communicate with a doctor or health care staff?"

On 05/12/25 at 03:05 PM, a phone interview was done with R9's Family Representative (FR)1. FR1 stated that R9 speaks only Vietnamese.

On 05/15/25 at 08:06 AM, an interview was done with the Social Services Director (SSD) in her office. Regarding R9's BIMS assessment not being completed, SSD confirmed she attempted to conduct the assessment using "the language line" but R9 "had a poor response" to questions asked by the interpreter, so she had marked that R9 is rarely/never understood. When asked what the language line is, SSD explained it is interpreter services by phone. When asked what language she used, SSD responded that she used a Cantonese speaker. State Agency informed SSD that FR1 had stated that R9 speaks only Vietnamese. SSD acknowledged that R9's "poor response" on the previous BIMS assessment was likely due to the use of interpreter services in the wrong language. SSD agreed that the assessment would need to be re-done.

On 05/15/25 at 01:22 PM, an interview was done with FR1 and R9 at her bedside. Using FR1 to interpret, R9 answered all questions from the State Agency (SA) without hesitation and with great animation. R9 could barely stop talking. When asked about her memory, FR1 stated R9 has a great memory and "remembers everything." When asked if R9 could speak Cantonese, FR1 responded "no, she can understand only very little Cantonese but doesn't speak it," and confirmed that Vietnamese is R9's native language.

Review of the facility's policy and procedure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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F 641	Continued From page 32	F 641		

Conducting an Accurate Resident Assessment, last revised 04/28/25, revealed the following:

"The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychological problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status."

2) Record review on 05/13/25 (Face sheet). R201 is a 75-year-old female admitted to the facility on 01/23/24. Diagnosis includes left sided weakness from a stroke. Unspecified dementia without behavioral disturbance.

Observations of R201 on Piikoi 2 unit on the following dates: 05/12/25; 05/13/25; 05/14/25; and 05/15/25. R201 wandered (while ambulating) in the hallway on and off the unit unsupervised.

MDS quarterly review ARD 04/26/25 reviewed on 05/13/25. R201 is severely cognitively impaired. Needs supervision or touching assistance when walking. Diagnosis includes stroke, coronary artery disease and Diabetes Mellitus. Two or more falls since admission. R201 was not coded as wandering although she is coded with a Wander/elopement alarm that is used daily.

Interview with the MDS coordinator (MDSC) 1 on 05/15/25 at 1:00 PM in her office. The surveyor asked her why R201 was coded as having a wander guard on daily but wasn't coded with any behaviors of wandering. MDSC1 said, the behavior might not have been observed during the 7-day period. The surveyor asked her if it was an error, since observations have been made several times a day of R201 wandering on

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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F 641	Continued From page 33 and off the unit between 05/12/25 and 05/15/25.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 34	F 656		

local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to develop and implement a person-centered Comprehensive Care Plan (CP) for 3 Residents (R), 9, 75, 211 of 36 residents sampled. As a result of this deficient practice, these residents were placed at risk for a decline in their quality of life, they did not have sufficient information to meet the residents medical, physical, mental, psychosocial needs and prevented them from attaining their highest practicable well-being.

Findings include:

Cross-reference to F676 Activities of Daily Living (ADLs)/Maintain Abilities.

1) Despite identifying that Resident (R)9's preferred language is Vietnamese and would like interpreter services to communicate with health care staff, the facility failed to develop and implement a person-centered communication plan that accurately reflected her needs.

2) On 05/12/25 at 04:41 PM record review of R75's Electronic Health Record (EHR) revealed she is a 76-year-old who was admitted to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 35 facility on 02/15/24 with diagnoses that include, but are not limited to, vascular dementia, unspecified severity, with other behavioral disturbance, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, pain, unspecified and constipation, unspecified. R75 had a Minimum Data Set (MDS), that was a quarterly review, with an Assessment Reference Date (ARD) of 11/12/24 with a Brief Interview for Mental Status (BIMS) Exam summary score of 99, indicating the interview was not successful and R75 has an MDS Significant Change that had an ARD of 02/20/25 with a BIMS asking "Should Brief Interview for Mental Status be Conducted?" and "No (resident is rarely/never understood)" was checked, indicating the BIMS exam was not done with R75. Review of R75's MDS Section GG - Functional Abilities and Goals revealed she is dependent upon staff for her toileting hygiene. Review of R75's Care Plan (CP) revealed the following: o BOWEL AND BLADDER ELIMINATION The resident is incontinent of bowel and bladder due to impaired functional mobility and cognitive deficit. Date Initiated: 02/23/2024 Revision on: 03/12/2025 o The resident will remain free from skin breakdown due to incontinence and brief use through the review date. Date Initiated: 02/26/2024 Revision on: 03/12/2025 o Resident wears disposable brief and incontinent of bowel and bladder. Date Initiated: 02/23/2024 Revision on: 02/26/2024 o Check for incontinence during established	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 656	Continued From page 36	F 656		

rounding process and prn. Clean peri area and apply moisture barrier with each brief change. Date Initiated: 02/23/2024

On 05/14/25 at 05:30 PM Observed R75 in her room in her bed yelling "help". Staff responded to R75.

On 05/14/25 at 05:38 PM interviewed Certified Nurse Aide (CNA) 35 in the nurse's station. Inquired if she is familiar with working with R75 and she said "yes". Inquired if R75 is incontinent of bowel and bladder (B&B) and CNA35 confirmed R75 is incontinent of B&B. Inquired how staff know R75 needs assistance if she is incontinent of B&B and CNA35 stated resident will use the call light or staff check her every 2 hours to clean her up. Inquired if resident can assist in moving when she is having her adult brief changed and CNA35 stated resident is able to move around in her bed. Inquired if R75 has any skin problems such as rash, moisture associated skin damage (MASD) or pressure ulcer and CNA35 stated R75 does not have any skin issues at this time. Inquired of CNA35 if R75 has a urinary tract infection and CNA35 said R75 does not have a UTI.

On 05/15/25 at 06:12 AM observed CNA60 change R75's adult brief. CNA60 was able to gather the supplies needed, perform hand hygiene and put on clean gloves. CNA 60 wore appropriate Personal Protective Equipment (PPEs) which also included a gown and mask. CNA60 told R75 what she was going to do. CNA60 provided privacy for R75 by closing the bedside curtain. CNA60 opened R75's brief and started wiping R75's perineal area. CNA60 was observed wiping from the back going upward and

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 656	Continued From page 37	F 656		

forward. Inquired of CNA60 if she should be wiping from the back to forward and CNA60 stated "no". Inquired of CNA60 how R75's skin looked and CNA60 stated resident's groin looks well with no skin breakdown. CNA60 turned R75 to her side with R75's assistance. CNA60 wiped R75's anus and buttocks. Inquired how R75's skin looks and CNA60 stated R75 had some reddened areas to her bottom (right buttock) and right back of right leg where her buttock meets her leg, right and left feet also have reddened areas on the bottom of R75's feet. CNA60 was able to use R75's call light to call for the nurse. RN30 confirmed these areas were new skin breakdown for R75. Inquired of CNA60 if she had training on how to provide peri-care to the residents at the facility and CNA60 stated she did during orientation last October.

On 05/15/25 at 06:35 AM interviewed CNA22 at the nurse's station. Inquired how she wipes a female resident when she is providing peri-care. CNA22 stated she "wipes from front to back". Inquired why she would not wipe back to front and she stated, "because it's dirty".

05/15/25 10:20 AM interviewed Director of Nursing (DON) in her office. Inquired of DON on how staff are to provide peri-care to residents and she stated the steps of peri-care that included wiping front to back. Inquired why staff should not wipe back to front and DON stated it would be contamination, could cause an infection and confirmed it puts the resident at risk for UTI (urinary tract infection) especially if they have a BM (bowel movement).

3) R211 is a 68-year-old male admitted to the facility on 04/15/24 with diagnoses that include

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 38 major depressive disorder single episode, generalized anxiety disorder, and post-traumatic stress disorder. A MDS with an ARD of 04/17/25 noted that R211 had a BIMS score of 13, which indicated that R211 is cognitively intact. On 05/12/25 at 01:00 PM, a review of the facility's Trauma-Informed Care (TIC) policy stated, "6. Resident centered, culturally competent care plans are developed to reflect resident needs and preference related to trauma..." On 05/13/25 at 01:55 AM, interviewed the Social Services Director (SSD) in her office. A concurrent review was done for a Social Services Psychosocial Evaluation -V4 completed on 06/22/24 in where "10. Describe Trauma", noted a documented resident response, "Large crowds makes resident anxious". SSD confirmed that R211's initial and current care plan did not contain a specific TIC care plan that listed the identified trigger and interventions on how to manage it.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 657	Continued From page 39 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to revise one Resident (R) 119 of four residents sampled for dialysis, Care Plan (CP). The facility also failed to provide an intervention to care for R119's dialysis access site after he returned from dialysis with a pressure dressing covering his access site. The deficient practice puts the resident at risk of decreased blood flow and/or occlusion of the access site. Findings include: On 05/13/25 at 09:22 AM R119 was observed in his room in his bed with a dressing on his upper left arm. Inquired of R119 where the dressing was applied and he stated it was applied at the dialysis center yesterday. Inquired if the nurses ever take off the dressing when he returns from dialysis and he confirmed "sometimes they take it off and put on Band-Aids if it is still bleeding". Record review of R119's Electronic Health	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 657	Continued From page 40 Record (EHR) revealed he is a 64-year-old was admitted to the facility on 12/04/24 and his diagnoses include, but are not limited to, hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease, type 2 diabetes mellitus with diabetic polyneuropathy, unspecified dementia, unspecified severity, with other behavioral disturbance and dependence on renal dialysis. Review of R119's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/13/25 revealed his Brief Interview for Mental Status (BIMS) Exam summary score of 11 indicating he is cognitively mildly impaired. Review of R119's care plan for hemodialysis included: HEMODIALYSIS The resident is on Hemodialysis due to ESRD (End Stage Renal Disease). Date Initiated: 09/10/2021 Revision on: 09/17/2021 ·He will have no s/sx of complications from Hemodialysis through the review date. Date Initiated: 09/10/2021 Revision on: 04/02/2025 Target Date: 06/29/2025 ·Do not draw blood or take B/P to left arm with AVF (Arteriovenous fistula) Date Initiated: 09/10/2021 Revision on: 05/23/2022 LPN RN ·Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis	F 657		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 657	Continued From page 41 3x/week (Tues-Thurs- Sat) [Mon, Weds., Fri. and sometimes Tuesday] CNA LPN Date Initiated: 05/23/2022 Revision on: 05/23/2022 RN o Monitor for dry skin and apply lotion as needed. Date Initiated: 05/23/2022 CNA LPN RN o Monitor labs and report to doctor as needed. Date Initiated: 05/23/2022 LPN RN o Monitor VITAL SIGNS every shift. Notify MD of significant abnormalities. Date Initiated: 09/10/2021 Revision on: 09/10/2021 CNA LPN RN o Monitor/document/report PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. Date Initiated: 09/10/2021 LPN RN o Monitor/document/report PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 42 Date Initiated: 05/23/2022 LPN RN o On Hemodialysis every Tues-Thurs-Sat [Mon, Weds., Fri. and sometimes Tuesday] at ... Date Initiated: 09/10/2021 Revision on: 05/23/2022 Resident has episode of refusing scheduled dialysis. Schedule make up HD with dialysis center. Notify MD. Date Initiated: 02/07/2025 On 05/14/25 at 08:59 AM interviewed R119 who was sitting in his wheelchair in the hallway outside of his room. Inquired when R119 went to dialysis the day before and he stated he "Went to dialysis at 11 am, hook up was at about 12, and returned by 5:30". At this time observed resident still had a pressure dressing to his left upper arm intact covering his access site. Inquired why staff had not removed the pressure dressing and R119 stated dialysis staff told him to remove it to prevent it from ruining it (access site). R119 stated he "forgot to take it off and forgot to tell the nurse to take it off". On 05/14/25 at 09:07 AM interviewed Registered Nurse (RN)40 near the medication cart. Inquired of RN40 who is supposed to take off R119's pressure dressing when he returns from dialysis and she stated night shift will take the pressure dressing off resident's access site. Inquired if RN40 had assessed R119's dialysis access site and she stated, "he took off the dressing". Requested RN40 to look at R119's left arm as he still had the dressing on. RN40 took off R119's	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 43	F 657		

dressing. RN40 stated he has a strong bruit. Inquired of RN what she must assess and she said, "the bruit and thrill". Inquired how she assesses for the bruit and she stated, "Palpating for the bruit" and "Oh I'm nervous now. I'm listening to the bruit and palpating for the thrill". Inquired of RN40 if facility provided training on how to work with residents receiving dialysis and she confirmed she had training upon orientation. RN40 stated sometimes when the resident is bleeding, we put on a new dressing. RN40 stated sometimes the R119 is cranky in the morning if you wake him up, and he was covered head to toe and that is why she did not see that he still had the pressure dressing to his upper left arm this morning.

05/14/25 05:16 PM interviewed RN30 in the nurse's station. Inquired who is supposed to take off R119's pressure dressing when he returns to the facility and RN30 confirmed she did not remove the resident's pressure dressing yesterday (05/13/25). Inquired when did R119 return to the unit from dialysis and RN30 stated at 4:10 PM. RN30 explained that she started at 4:30 PM yesterday. RN30 stated they (nurses) usually take the pressure dressing off within 2 hours of the resident returning from dialysis. Inquired of RN30 if she took off R119's pressure dressing on 05/13/25 and RN30 confirmed she did not take it off and stated she checked on him later and he was sleeping around 7 or 7:30 PM. RN30 stated she worked till 11:30 PM on 05/13/25. Inquired of RN30 what the nurse has to assess for with R119's dialysis access site and RN30 stated she assess the access site with the pressure dressing in place. RN30 stated she assess if it's swollen, check for the bruit by using the stethoscope to listen for the woosh sound and feels with her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 44 hands (palpates) for the thrill. 05/14/25 09:15 AM interviewed Director of Nursing (DON) in her office and inquired how long the pressure dressing is to remain on residents who receive dialysis and DON stated she contacted the dialysis centers and inquired of them. DON stated she is in the process of training all facility nurses on when the pressure dressing should be removed after dialysis. DON confirmed they did not have this in place prior to her calling the dialysis center.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,	F 676		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 676	Continued From page 45 §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the proper care and treatment including assistive devices/tools to improve, promote the communication abilities and to communicate needs and express choices for 2 Residents (R)9 and 203 of 3 residents sampled. Despite identifying upon admission that their primary language was not English, the facility failed to implement the use of alternative communication methods, such as a communication board, non-verbal pain assessment tools or commonly used phrases in their primary language. As a result of this deficient practice, the residents were placed at an increased risk of not having their needs met, hindered from attaining their highest practicable well-being and placed at risk for decrease in quality of life. Findings include: Cross-reference to F641 Accuracy of Assessments.	F 676		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 676	Continued From page 46	F 676		

1) Despite identifying that R9's preferred language is Vietnamese and would like interpreter services to communicate with health care staff, the facility failed to develop and implement a person-centered communication plan that met her needs.

On 05/12/25 at 03:05 PM, a phone interview was done with R9's Family Representative (FR)1. FR1 stated that R9 speaks only Vietnamese, and she has never seen or known the facility to use interpreter services. FR1 further stated that no staff speak Vietnamese, and despite requesting Vietnamese-speaking services several times for R9, FR1 had never been informed that phone interpreter services were available. When asked if the facility ever calls her to ask her to help interpret, FR1 responded, "no, never." FR1 added that even when she visits, staff have never asked her to interpret despite observing her and R9 conversing in Vietnamese.

Review of R9's Comprehensive Care Plan (CP) revealed the following planned interventions under Cognitive/Communication:

"Family serves as a translator to validate needs as needed."

"The resident is able to communicate by using communication board and translator."

The CP also documented "Primary language spoken is Cantonese/Vietnamese" (two different languages from two different countries), despite none of her Minimum Data Set (MDS) assessments ever indicating that she spoke any other language but Vietnamese.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 676	Continued From page 47 On 05/13/25 at 08:01 AM, observations were done at the bedside with R9. No communication boards, communication books, or common phrases in Vietnamese were at or near the bedside, however there were laminated picture cards with Vietnamese words hanging from a bulletin board past the foot of the bed (not within R9's reach). State Agency (SA) grabbed the picture cards off of the bulletin board, handed them to R9 and asked if she was "OK," using a thumbs up motion while asking. R9 indicated "no." Smiling and repeatedly pointing to her toes (both with her hands and a stick device she had) and saying what sounded like "ow," R9 appeared to be complaining of pain. SA flipped through the pictures to find the Vietnamese word for pain and showed R9 the word "dau" with a picture of a crying man above it. Still smiling, R9 nodded her head, repeatedly pointed at the picture of the man crying and at her toes, all while vocalizing the word "dau" which sounded like "ow, ow, ow." Motioning with her hands, R9 indicated she had pain from her right hip, down her right leg, and on all of her toes. Observed at this time, as this Surveyor flipped through the Vietnamese picture cards, that there were no pain scale picture cards either in the packet, on the board, or at the bedside, so that the level or intensity of her pain could be assessed. On 05/14/25 at 09:05 AM, an interview was done with Registered Nurse (RN)3, who operates as both Nurse Supervisor for the unit, as well as a floor nurse when coverage is needed. RN3 stated she was familiar with R9's care and confirmed that R9 "understands limited English." When asked how staff communicate health information or conduct assessments with R9, RN3 reported that they mostly use gesturing and monitor her	F 676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 48	F 676		

facial expressions. When asked about phone interpreter services, RN3 stated that they are available, but she has never used them before. RN3 reported that staff nurses do not really use the interpreter services by phone, "mostly just the APRN [Advance Practice Registered Nurse]" uses it.

Review of the facility's policy and procedure on Resident Rights, Right to Information and Communication, last revised 03/2023, revealed the following:

"If a resident ... understanding of English ... is inadequate for their comprehension, a means to communicate information in a language or format familiar to the resident ... will be used."

"The facility will have written translations ... and make services of interpreter available as needed."

2) R203 is a 93-year-old male admitted to the facility on 02/10/24. A MDS with an Assessment Reference Date of 02/13/25 noted that R203 was identified as having a preferred language of Mandarin and was coded "yes" for "need or want" an interpreter to communicate with health care staff.

On 05/13/25 at 01:46 PM, interviewed the Social Services Director (SSD) in her office. The SSD stated that the facility utilizes a professional translator service called "MERFi" and instructions should be posted at each nursing station. The SSD also stated that R203 should have a communication board in his room that is made up of laminated sheets with pictures and words in Mandarin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 49 On 05/13/25 at 03:00 PM, met with Certified Nurse Aide (CNA) 40 in R203's room. Resident was asleep at the time. CNA40 stated that R203 primarily speaks Chinese. When CNA40 was asked if there are any communication tools that she uses, she stated that there are sheets with pictures that can be used. CNA40 confirmed it was called a communication board. When asked to see it, CNA40 looked around the room and could not locate it. The communication board was observed to be on a hook in the top corner of a corkboard located on R203 roommate's side of the room. CNA40 also stated that she was unaware of the MERFi translator services. On 05/14/25 at 11:22 AM, met with CNA41 in R203's room. R203 was asleep at the time. CNA41 stated that R203 speaks Chinese and communicates to R203 by using gestures and proceeded to provide an example of a gesture by moving his hand to mouth to represent eating. When CNA41 was asked if there are any communication tools that he uses like a communication board that has picture with Chinese language written on them, CNA41 stated that he was not aware of that. The communication board was observed to be on a hook in the top corner of a corkboard located on R203 roommate's side of the room. CNA41 also stated that he was unaware of the MERFi translator services. A facility policy titled, "RESIDENT RIGHTS. Right to Information and Communication" with a revision date of 03/2023, stated, "If a resident ...understanding of English ...is inadequate for their comprehension, a means to communicate information in a language or format ...will be	F 676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 50 used."	F 676		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide two Residents (R) 166, 216, out of two sampled, the amount of treatment/services to maintain and/or prevent a decline in range of motion (ROM) as evidenced by inconsistent application of splint and ROM exercises. This puts the residents who have limited mobility at risk for decline in ROM and further contractures. Findings include: 1) R166 was admitted to the facility on 10/27/23 with diagnosis, not limited to, Hemiplegia,	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 51 unspecified affecting left non-dominant side (weakness or paralysis on the left side of the body). R166 has contractures to left hand and bilateral elbow. On 05/12/25 at 08:58 AM, observed resident with bilateral arm contractures. Noted a towel hand roll to left hand, but no splint to right arm noted. On 05/13/25 at 12:25 PM, observed hand roll to left hand, but no splint to right arm noted. On 05/14/25 at 08:45 AM, observed no hand roll on left hand and no right arm splint. On 5/14/25 at 09:15, interview with Restorative Nurse Aide (RNA)1 completed. RNA1 confirmed that R166 should have right arm splint and left hand roll applied every day. RNA1 also stated that R166 should be provided ROM at least six times a week for 15 minutes for both upper and lower extremities. RNA1 stated that they have been short of staff and at the most R166 has been only getting ROM two to three times a week. RNA1 confirmed that both application of the splint and ROM is important for preventing and worsening of contractures. On 05/14/205 at 09:30 AM, interview with Restorative Nurse Aide Supervisor (RNAS) completed. RNAS reviewed the RNA treatment administration record (TAR) and stated that splint/ROM was completed for couple of days and was not done consistently. When RNAS was asked the importance of the splint and providing ROM to residents, RNAS specified that it was important to prevent contractures. Record review of R166's Electronic Health Record (EHR) completed. The care plan that was initiated on 03/03/25 noted focus areas of	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 52 ADL (activities of daily living) deficit, with interventions of "nursing rehab/restorative: Splint/Brace Program#2-RNA to apply rolled towel between RUE (right upper extremity) upper arms/trunk to increase abduction x4 hours, resting hand splint to RUE, rolled wash cloth to left hand daily as tolerated." Focus area for mobility noted: "nursing rehab/restorative: Active ROM Program #1-RNA to provide assistance and verbal cues to resident to perform AAROM (Active Assisted Range of Motion) and PROM (Passive range of motion) exercised to BUE (Bilateral Upper Extremity)/BLE (Bilateral Lower Extremity), all planes, x15 minutes six times a week as tolerated." Review of R166 TAR noted that for the month of April, AAROM/PROM and application of splint/brace was only completed on 04/23/25, 04/24/25, 04/29/25 for the month of April. The AAROM/PROM and splint/brace was only completed on 05/01/25, 05/07/25, 05/09-05/10/25, 05/12/25, and 05/14/25 so far for the month of May. 2) R216 was admitted to the facility on 07/22/24, with diagnoses not limited to, Hemiplegia (paralysis on one side of the body) and Hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting right dominant side. On 05/12/25 at 09:15 AM, observed R216 asleep in bed laying on back, easily arousable, hands crossed and resting on abdomen. Air mattress on with bilateral foot pads intact. On 05/12/25 at 03:41 PM, observed R216 asleep in bed, laying on back, with bilateral foot pads on.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 53	F 688		

R216 hands crossed and resting on chest. No observed ROM activity this shift.
On 05/13/25 at 08:05 AM, observed R216 asleep in bed laying on back, easily arousable, denies any pain. Hands crossed, resting on chest, and bilateral foot pads on.
On 05/13 at 09:30 AM, observed CNA2 assisting R216 with breakfast. Head of bed elevated to 90 degrees. At 10:45 AM, observed R3 in bed, lying on back, hands crossed and resting on chest.
On 05/13/25 at 12:10 PM, observed R216 asleep in bed, laying on back. Hands crossed, resting on chest, and BLE with foot pads on.
On 05/13/25 at 03:48 PM, observed resident asleep in bed, laying on back. Hands crossed, resting on chest, and BLE with foot pads on. No ROM activity noted this shift.
On 05/14/25 at 08:40 AM, observed R216 asleep in bed, positioned on left side.
On 0514/25 at 12:00 PM, observed resident asleep in bed, laying on back. Hands on chest, BLE with foots pads on.
On 05/14/25 at 03:00 PM, observed resident asleep in bed, laying on back. Hands crossed, resting on chest, and BLE with foot pads on.

On 05/14/25 at 01:28 PM, interview with RNA1 completed. RNA1 stated that R216 is on the Restorative Nursing Program (RNP) and should be receiving PROM to BUE/BLE, stretching at least three times a week. RNA1 stated he has not been able to provide R216 the frequency of PROM he needs due to short of staffing. RNA1 stated he completed PROM this morning and will probably be the only one R216 will have this week.

Record review of R216's EHR completed. The "Care Plan" noted with a "Focus on Mobility" that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 54 was initiated on 01/15/25, and interventions to note: "Nursing Rehab/Restorative: PROM Program #1-RNA to provide PROM exercises to BUE/BLE for strengthening, all planes, bilateral ankle ...stretching 3x30s, LUE (left upper extremity) with 1-2 cuff weights x15 min, as tolerated. Review of the R216's TAR showed PROM only completed on 04/16/25, 04/18/25, 04/26/25, 04/30/25 for the month of April, and 05/08/25, 05/14/25 so far for the month of May. On 05/14/25 at 01:45 PM, interview with Director of Nursing (DON) completed. DON confirmed that R216 and R166 did not have consistent PROM completed. DON acknowledged that PROM is very important to maintain the residents' mobility and prevent further contractures. Review of the facility's "Restorative Program" policy's intent states, " ...program is designed to assist the facility team help residents to achieve and maintain their highest functional level."	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 55	F 689		

and review of policy, the facility failed to ensure two Residents (R)201 and R49, of six residents sampled for accident hazards, had their risk of preventable accidents occurring minimized. R201 who wanders didn't receive adequate supervision from the staff and R49 did not have a safe designated smoking area for him to smoke. As a result of this deficient practice, there was increased risk of avoidable accidents and injuries by not providing the appropriate planning, monitoring and/or implementing the interventions to meet their identified needs.

Findings include:

Cross reference to F641.

1) The following observations were made of R201 on the Piikoi 2 unit between 05/12/25 to 05/15/25:

05/12/25 at 12:30 PM on the Piikoi 2 unit. R201 walked briskly up and down the hall from her room at the end of the hall toward the nurse's station.

05/13/25 at 09:07 AM on the Piikoi 2 unit. R201 was unaccompanied by staff when she walked around in the hall at the end of the hall near her room.

05/13/25 in the morning, R201 was observed on the Lewalani unit 2 by another surveyor. She came up from behind unexpectedly and surprised the surveyor. She wasn't assisted or supervised by staff.

05/14/25 at 01:37 PM at the Piikoi 2 nurse's station. R201 walked briskly down the hall toward the nurse's station and turned right toward the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 56	F 689		

Lewalani unit. A moment later staff came quickly around the corner and called out to R201 to come back. A few minutes later she was observed to walk back toward her room with the staff.

05/14/25 at 04:58 PM at the Piikoi 2 nurse's station. R201 was observed wandering in the hallway.

Social Services (SS) Quarterly & Annual Note dated 5/9/2025 reviewed on 05/13/25. R201 is a Resident is 75 years old, admitted to facility on 1/23/2024 with admitting diagnosis of Hemiplegia and hemiparesis after a stroke affecting her left side. R201 also has dementia, unspecified without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. R201 is on psychotropic medications.

Care plan reviewed on 05/13/25. Fall. The resident is high risk for falls and serious injuries due to unsteady gait, dense Left hemiplegia and impaired balance, cognition & communication deficits, and poor safety awareness...Provide close supervision or frequent visual check when awake...R210 is impulsive and is a wanderer, She likes her freedom. Monitor for impulsivity, (date initiated 02/11/2025).

Interview with the Social Services Director (SSD) in the social services office on 05/15/25 at 10:10 AM. The surveyor discussed R201s behavior of wandering unsupervised on the unit. She responded that During activities when music is playing, R201 is very calm. She likes music. Staff here try to redirect her and keep an eye on her when she is wandering. When asked if she thinks R201 needs more supervision she said, yes, because it is upsetting to the other residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 57	F 689		

when she takes their food.

Interview with Licensed Practice Nurse (LPN) 2 on 05/15/25 at 10:24 AM. The surveyor asked if she was familiar with R201. LPN2 said, before R201 was on another floor. Her level of function was more declined. She had a Gastrostomy (G)-Tube and after they took the G-tube out she got better, then she started walking... The staff try to redirect her when she is wandering around the unit and keep her safe. The surveyor asked LPN2 if R201 needs more supervision. LPN2 said, she's okay if she stays on the floor where we can supervise her. If she goes on the elevator, or goes downstairs, the wander guard will alarm. The surveyor asked if the wander Guard works. LPN2 said yes, it works.

Interview with the Social Services Assistant (SSA) 1 in the social services office on 05/15/25 at 11:30 AM. The surveyor discussed R201s behaviors of wandering alone on the unit and sometimes taking the other residents' foods. When asked if she feels that R201 needs more supervision, the SSA1 responded that she thinks she needs more supervision to keep her safe.

05/30/25 review of policy on Quality of Care Accident Hazards/Supervision/Devices dated 03/2023 read; Guidelines:6. Efforts to minimize risk to residents will include individualized, resident-centered interventions to reduce individual risks related to hazards in the environment. Interventions will be modified when necessary. Wandering and Elopement. 1. The facility will strive to identify potential safety issues for residents who wander. 2. Residents who wander will be evaluated to identify root causes to the degree possible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 58 2) R49 is a 71-year-old male admitted to the facility on 11/07/15 for long-term care. His admitting diagnoses include, but are not limited to, right hip osteoarthritis (a disease where the flexible, protective tissue at the ends of bones wears down, worsening over time, often resulting in chronic joint pain and stiffness). A review of R49's most recent MDS assessment with an ARD of 04/17/25 revealed that R49 can and does use a wheelchair independently for mobility and identifies him as a current smoker. Review of facility policy and procedure, Physical Environment Smoking - Supervised Smokers, last revised March 2023, revealed the following: "The Facility will furnish the designated smoking area with a fire extinguisher and proper receptacle for extinguishing smoking materials." On 05/12/25 at 01:49 PM, the following observations were done of R49 when he went downstairs to smoke a cigarette: Recreational Aide (RA)1 arrived on the unit to escort R49 to the designated smoking area, pushing him in his wheelchair. RA1 offered him a smoking apron, he refused. RA1 pushed R49 out to the designated smoking area which is an unpaved, uneven, area with dirt and gravel, approximately 10 feet wide and 30 feet long, in a corner of the parking lot beneath a large tree and surrounded by several flammable plants and brush. In the back of the designated space was a fire-proof receptacle for used cigarettes and a couple of metal chairs. At the front of the designated space was a plastic trash can with a thin plastic trash liner. Nowhere near the designated smoking area was a fire extinguisher observed. RA1 pushed and stopped R49's wheelchair at the front of the designated	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 59 smoking area, directly in front of the plastic trash can. When asked where he usually disposes of his cigarette butts, R49 responded either in the plastic trash can or the fire-proof receptacle, whichever is closer. Once R49 was done smoking, he extinguished his cigarette butt and handed it to RA1, who turned and put it in the plastic trash can. On 05/14/25 at 09:53 AM, an interview was done with the Director of Nursing (DON) in her office. DON confirmed that R49's used cigarette butts should only be discarded in the fire-proof receptacle, and that there should be a fire extinguisher immediately accessible in the designated smoking area.	F 689		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to manage pain adequately for 2 Residents (R)9 and R44 of 4 residents sampled for pain. Specifically, the facility failed 1) accurately assess and monitor R9's pain in a manner that she understood, resulting in inadequate pain control and 2) failed to manage R44's pain while being provided passive range of motion (PROM) exercises by the Restorative Nursing Assistant (RNA) and had not been pre-medicated prior. As a result of this	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 60	F 697		

deficient practice, these residents were prevented from attaining or maintaining their highest practicable level of well-being.

Findings include:

1) Cross-reference to F676 Activities of Daily Living (ADLs)/Maintain Abilities. Despite identifying that Resident 9's preferred language is Vietnamese and would like interpreter services to communicate with health care staff, the facility failed to assess and monitor her pain in a way that she understood.

Resident (R)9 is an 89-year-old female admitted on 04/25/23 for long-term care. Review of R9's Minimum Data Set (MDS) Annual Assessment with an Assessment Reference Date (ARD) of 03/31/25 revealed that R9 had indicated her "preferred language" was Vietnamese, and indicated "yes" to the question regarding " ... need or want an interpreter to communicate with a doctor or health care staff?"

On 05/12/25 at 03:05 PM, a phone interview was done with R9's Family Representative (FR)1. When asked about pain, FR1 reported that R9 complains of constant pain to her feet and toes. As far as she knows, R9 only receives acetaminophen for the pain, and it is "not very effective, every time you touch her [R9's] feet, she cries out in pain." FR1 stated that she has asked for topical pain patches to try, but the nurses tell her they need to check with the doctor and then never get back to her about it.

On 05/13/25 at 08:01 AM, observations were done at R9's bedside and an interview was attempted as she indicated that she was in pain,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 61	F 697		

despite smiling the whole time. Using picture cards found on a bulletin board out of her reach, R9 repeatedly pointed to a picture of a crying man with the Vietnamese word for pain, "dau," and motioned to her feet, toes, and right hip. When attempting to assess the level of her pain, it was noted that there was no Wong-Baker Faces Pain Rating Scale (a method for someone to self-assess and effectively communicate the severity of pain they may be experiencing. The scale contains a series of six faces ranging from a happy face at 0 to indicate "no hurt" to a crying face at 10 to indicate "hurts worst") available in the room. Attempts to ask R9 to rate her pain on a scale of one to ten in English produced no response.

Review of R9's electronic health record (EHR) revealed the following provider orders to manage her pain:

"Question resident about presence of pain or burning including pressure points. Monitor for pain using 0-10 scale. 0 for no pain, 10 for worst pain possible. If resident is not able to answer, use PAINAD scale [a tool that assesses pain levels in patients with cognitive impairments, such as delirium, or dementia]. every shift for pain."

Acetaminophen 500 milligrams (mg) "Give 1 tablet by mouth three times a day for PAIN."

Review of R9's diagnoses revealed no history or current diagnosis of dementia or delirium.

Review of the documented pain assessments done every shift for the month of May revealed R9's pain was consistently rated as "0."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 62	F 697		

Review of R9's Medication Administration Record (MAR) revealed her pain level consistently documented as "0" when administering her Acetaminophen every shift.

On 05/14/25 at 09:05 AM, an interview was done with Registered Nurse (RN)3, who operates as both Nurse Supervisor for the unit, as well as a floor nurse when coverage is needed. RN3 stated she was familiar with R9's care as she has served as her direct care nurse many times. When asked about R9's pain, RN3 confirmed that R9 "usually has pain on [her] feet." RN3 agreed that pain assessments should include pain level, location, and characteristics. When asked how staff assess R9's pain, RN3 stated that they use the pain scale pictures that are at the bedside. Concurrent observation with RN3 at R9's bedside was done. RN3 confirmed there was no Wong-Baker Pain Scale in the room. Observation of RN3 looking through the picture cards that were available at the bedside noted she was unfamiliar where to find the word for pain and did not know what picture to look for. RN3 confirmed she had been the direct care nurse for R9 the previous two days and administered R9's pain medication during her care. When asked how she assessed R9's pain level, RN3 stated that she looked for facial grimacing, and there was none. While RN3 was looking through the picture cards, R9 again vocalized the Vietnamese word for pain, grabbed the picture cards from RN3, flipped to the picture of the man crying, and repeatedly pointed back and forth from the picture to her right hip down to her toes. R9 had a slight smile on the entire time and did not display any facial grimacing. Asked RN3 if she thought R9 was indicating she currently had pain, RN3 answered "yes." RN3 acknowledged the possibility that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 63	F 697		

culturally R9 may not display facial grimacing when she is in pain, and that to base a pain assessment on the presence of facial grimacing alone was not appropriate.

On 05/14/25 at 09:46 AM, an interview was done with the Director of Nursing (DON) in her office. DON confirmed that the Wong-Baker Pain Scale should be available either at the bedside or with the nurse and should be used for non-English speaking residents. DON also confirmed that pain assessments should include characteristic, location, and level of pain.

On 05/15/25 at 01:22 PM, an interview was done with FR1 at the bedside as she visited R9. FR1 stated that RN4 had just given R9 her Acetaminophen. When asked if RN4 had done a pain assessment or asked her to translate, FR1 responded "no, she did not ask her [R9] anything about pain." Using FR1 to translate, R9 was able to communicate that she currently has pain 7-8 out of 10, and that it starts at her right hip and radiates down to her toes.

On 05/15/25 at 01:28 PM, interview was done with RN4. RN4 confirmed that she did just give R9 her Acetaminophen and that she did not assess her pain. Upon questioning, RN4 agreed that standard nursing practice requires that when administering a medication for pain, pain must be assessed. Confirmed that she is aware that R9 does have pain and where her pain is located.

Review of the facility's policy and procedure Quality of Care, Pain Management, last revised 03/23, revealed the following:

"Residents are assessed and evaluated to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 64 identify pain and manage pain/symptoms ... Expressions of pain may be verbal or nonverbal ... The presence of pain may be obtained by talking with the resident, directly examining the resident, and observing the resident's behavior." "An evaluation of pain based on professional standards of practice may necessitate gathering the following information ... Characteristics of pain, such as: (intensity, pattern, location, frequency and duration); ..." 2) On 05/13/25 at 07:50 AM observed R44 in her room in her bed. Observed R44 has contractures to both hands and no splints were seen on her hands. Record review of R44's EHR revealed she is 71 years old and was admitted to the facility on 07/14/15 and her diagnoses include, but are not limited to, pain, unspecified, encounter for attention to tracheostomy (medical procedure that involves creating an opening in the trachea (windpipe) for breathing), aphasia (not able to communicate) and dysphasia (difficulty swallowing) following nontraumatic subarachnoid hemorrhage (bleeding in the brain), and contracture to right and left hands. Review of R44's MDS with an ARD of 02/07/25, section GG - Functional Abilities and Goals, GG0130. Self-Care states R44 is "Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity." for all of her activities of daily living (ADLs) and hygiene. R44 is also coded as being dependent upon staff for all of her mobility needs such as rolling her left and right in her bed. A Brief Interview for Mental Status (BIMS) Exam was done and a summary score of 99 was coded for R44, indicating the	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 65 interview was not successful. Review of R44's Care Plan (CP) includes the following: ADL Resident has an ADL self-care performance deficit r/t non traumatic subarachnoid hemorrhage and PCOM aneurysm. She is bed bound, non-verbal, with non-functional extremities and bil. (bilateral) contractures to hands/wrists. Also, she is unable to use call light button for her needs of assistance. Date Initiated: 08/29/2015 Revision on: 06/19/2019 o CNA to provide passive ROM to upper and lower extremities daily during care as tolerated. Date Initiated: 09/09/2015 Revision on: 09/09/2015 Date Initiated: 08/29/2015 NURSING/RESTORATIVE: Splint/Brace Program #2 - RNA to provide PROM exercise and gentle prolonged stretch prior to DONNING left and right hand rolls. Keep handrolls for 4-6 hrs. Check skin integrity after DOFFING. Report skin breakdown. Document the number of minutes spent doing this program. Date Initiated: 08/02/2022 Revision on: 04/16/2025 Disease Process non traumatic subarachnoid hemorrhage Date Initiated: 09/20/2015 Revision on: 06/19/2019 contractures, thrombus formation, skin-breakdown, fall related injury through the next review date. Date Initiated: 09/21/2015	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 66 Revision on: 02/20/2025 Target Date: 08/07/2025 o NURSING REHAB/RESTORATIVE: PASSIVE ROM Program #1 - RNA to provide gentle PROM to B UE/B LE, 12 reps x3 sets in all planes of motion. Document number of minutes to complete task. Date Initiated: 07/31/2022 Revision on: 05/09/2024 o COMMUNICATION Name of resident is non verbal. She has Aphasia, communication problem and impaired cognition, visual deficit r/t nontraumatic subarachnoid hemorrhage. Date Initiated: 10/11/2015 Revision on: 11/23/2020 Name of resident ADL needs will be met daily through next review Date Initiated: 10/13/2015 Revision on: 02/20/2025 Target Date: 08/07/2025 Anticipate her needs. Check resident at least q 2 hrs and as needed for incontinent care, turning and repositioning, suctioning needs, s/sx of pain, etc. Date Initiated: 10/12/2015 Revision on: 08/22/2023 Monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed. Date Initiated: 10/13/2015 Speak to her when doing care to provide stimulation. Observe her facial gestures Date Initiated: 04/23/2018 Revision on: 02/14/2022	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 67 PAIN Resident is at risk for pain r/t medical condition. She had previous SAH (subarachnoid hemorrhage), with PCOM (Posterior Communicating Artery) aneurysm, s/p PEG, and Tracheostomy. Date Initiated: 10/13/2015 Revision on: 05/21/2021 Will have no physical manifestations of pain/discomfort Date Initiated: 10/13/2015 Revision on: 02/20/2025 Target Date: 08/07/2025 Monitor for physical manifestations of pain. Administer analgesia as per orders. Date Initiated: 10/13/2015 Revision on: 05/21/2021 Monitor/record/report to Nurse any s/sx of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Date Initiated: 10/13/2015 Revision on: 05/21/2021 MOBILITY Resident has limited physical mobility r/t The resident will remain free of complications related to immobility, including Provide gentle range of motion as tolerated with daily care. Date Initiated: 06/03/2020	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 68 On 05/14/25 at 02:35 PM inquired of Director of Nursing who would be the RNA working with R44 on 05/15/25 with her PROM and DON stated she would look at the schedule and let surveyor know. On 05/14/25 at 04:54 PM observed R44 in her room in bed with no splints or rolls in her hands, lying on her right side. On 05/14/25 at 05:48 PM interviewed Registered Nurse (RN) 30 and inquired if R44 ever has hand rolls in her hands. RN30 confirmed resident has had rolled up wash clothes placed in her hands when she has worked and denies resident wears splints on her hands. 05/14/25 06:00 PM interviewed CNA92 assigned to work with who has worked second day on the unit and not familiar with R44. RN30 requested CNA92 roll up washcloths and place them in R44's hands. On 05/15/25 at 06:46 AM interviewed Certified Nurse Aide (CNA) 85 in the hallway outside of R44's room. Inquired how many staff are required to care for R44 and inquired if CNA85 does passive range of motion with R44. CNA85 stated resident requires two person assist with her ADLS. CNA85 stated she does not do PROM with R44, that she just provides care and turns resident. CNA85 stated "RNAs provides ROM (range of motion) for resident". On 05/15/25 at 08:50 AM an interview was conducted with the RNA35 at the nurse's station. Inquired of RNA35 when did she begin working with the resident? RNA35 stated "Long time ago, more than 5 years ago." Inquired why R44	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 69	F 697		

requires PROM and RNA35 stated "to prevent more contractures". Inquired what is being provided to address R44's ROM and RNA35 stated "PROM, stretching, all limbs". Inquired how often and how much assistance does R44 require and RNA35 stated "one person for PROM, requires total assistance from staff". Inquired what equipment or devices does R44 uses for ROM, mobility, or positioning and RNA35 stated "use hand rolls". Inquired how much time is required to provide the interventions and RNA35 stated "15-30 minutes". Inquired of RNA35 risk factors for developing a contracture, decline in ROM, mobility, or positioning for R44 and she stated, "How they reposition the patient, lack of exercises and not being mobile."

On 05/15/25 at 09:29 AM observed RNA35, perform PROM with R44. RNA35 was able to put on her personal protective equipment (gloves, gown and mask) as R44 is on enhanced barrier precautions due to her percutaneous endoscopic gastrostomy (PEG tube which is a feeding tube) prior to starting the PROM. RNA35 had another CNA help her re-position R44. RNA35 lowered R44's head of bd to lay her flat on her back. Inquired of RNA35 how long she was going to keep R44 in this position and she said 30 minutes. R44 coughed and RNA35 brought the HOB up. RNA35 was observed lifting R44's left arm all the way up with no stretching observed prior to lifting resident's arm straight up. R44 was observed with a lot of deep facial grimacing, eyes closed tightly and noted to be in pain. R44 is unable to speak and tell staff how she feels. Inquired of RNA35 if she looks at R44's face while she is performing PROM with resident and she said "yes". Inquired if RNA35 noticed R44 was in pain and she replied "yes". Inquired with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 70	F 697		

RNA35 what she can do and she said, "go slower". RNA35 continued to lift R44's left arm and surveyor stopped RNA35 as it was very painful for R44 who continued to have deep facial grimacing, her eyes were closed tightly and she started to cough. At this time recommended RNA35 assure R44 receives pain medicating prior to doing PROM.

On 05/15/25 at 09:55 AM inquired of RN40 who was at the medication cart outside of R44's room if R44 had an as needed pain medication that she takes before PROM or for pain. RN40 looked at resident's medication orders and found she did not have anything ordered for pain.

On 05/15/25 at 10:05 AM interviewed RNA35 and inquired how she knows what PROM she is to do with the R44 and she said, "it's rehab orders". Inquired how she received training on how to perform ROM and PROM. RNA35 stated she "did it a long time ago. We do not have a certificate for RNA, we are CNAs and do RNA work." RNA35 stated she trained in 2005.

On 05/15/25 at 10:14 AM inquired of RN40 if staff are to keep R44's HOB up and she said staff are to follow the sign that is posted near her bed (sign behind resident's bed state's keep HOB up 45 degrees).

On 05/15/25 at 10:43 AM interviewed DON in her office. Inquired what is R44's RNA program and DON stated "It should be PROM and handrolls. These are nursing interventions because they are in the care plan. Resident has been here for almost 10 years." Inquired if the rehabilitation department did an evaluation of R44 and DON stated she would look for the last one. Inquired of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 71 DON what staff are to do when residents are in pain when RNAs are performing PROM. DON stated staff are expected to stop the exercises and report it to the nurse. On 05/15/25 at 12:06 PM interviewed RN40 at the medication cart near R44's room. Inquired if RN40 was able to order pain medication for R44 and RN40 confirmed she ordered and gave resident prn (as needed) acetaminophen for pain. Inquired of RN40 how she knew R44 was in pain and RN40 stated she was able to determine R44 was in pain by her facial grimacing. Went with RN40 to check on R44 and noted PRN pain medication was effective; resident was sleeping and no facial grimacing was observed.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure that residents who require dialysis services are consistent with professional standards of practice. The facility failed to remove the pressure dressing for one of one resident Resident (R) 73 sampled, who was on dialysis. This deficient practice puts residents on dialysis at high risk for access clotting and complications. Findings include:	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 72 On 05/12/25 at 01:40 PM, observed R73, who went for dialysis in the morning at 05:00 AM and returned to the facility at 10:00 AM with left forearm fistula pressure dressing still on. R73 stated that the nurse will usually take it off after he comes back from dialysis. On 05/13/25 08:00 AM, observed resident left forearm fistula still with pressure dressing. Resident stated that they did remove it last night, but the nurse on the night shift reapplied a new dressing. On 05/13/25 at 11:35 AM, interview with Registered Nurse (RN) 2, when asked what the facility's process is in assessing the dialysis access, RN2 stated that they check the thrill, bruit, bleeding, and symptoms of infections every shift. RN2 noted that the night shift is responsible for removing pressure dressing. RN2 accompanied surveyor to R73's room to validate that the pressure dressing was still on. RN2 stated that resident was a bleeder and night shift reapplied a dressing to stop bleeding. RN2 admitted to not removing the pressure dressing as it was not endorsed by the night shift nurse that resident still had a pressure dressing on and was not able to assess R73's access yet as resident had an early appointment in the morning. RN2 finally removed the pressure dressing at 11:45 AM. On 05/14/25 at 11:45 AM, interview with Director of Nursing (DON) completed. DON agreed that pressure dressing should be removed couple of hours after dialysis and access checked for bleeding every shift, unless there is a doctor orders to leave dressing on. DON confirmed that	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 73 not removing pressure dressing puts the resident's access at risk for occlusion. On 05/15/25 at 8:40 AM, follow up interview with DON completed. DON stated that she called U.S. Renal Care (facility that the resident gets dialysis at) to find out what their recommendations are for removal of the pressure dressing if the resident is a bleeder. DON was told by dialysis facility that the pressure dressing could be left on for couple hours if bleeding is noted, but that it should be assessed at least every two to three hours until bleeding has stopped, and dressing should be removed. DON agreed that the dressing should not have been left on until the following morning.	F 698		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to adequately assess for and identify past trauma experienced by one of one Resident (R) 211 sampled for Trauma-Informed care (TIC). As a result of this deficient practice, R211 did not have his trauma triggers identified placing him at increased risk of re-traumatization and was hindered from attaining her highest practicable mental and psychosocial well-being.	F 699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	Continued From page 74 Findings include: R211 is a 68-year-old male admitted to the facility on 04/15/24 with diagnoses that include major depressive disorder single episode, generalized anxiety disorder, and post-traumatic stress disorder. A Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/17/25 noted that R211 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated that R211 is cognitively intact. On 05/12/25 at 01:00 PM, a review of the facility's TIC policy stated, "1. Staff will receive training related to trauma-informed care; 2. Residents will be screened upon admission to assist in the identification of residents who may be trauma survivors." On 05/12/25 at 02:18 PM, interviewed R211. When asked about past trauma in his life, R211 stated that when he was in "Vietnam", he sustained a knife wound and proceeded to lift his shirt displaying a scar extending across his chest. R211 stated that the scar is from the burning of the wound that was done to stop the bleeding. He declined to discuss the topic any further. On 05/13/25 at 01:04 PM, a record review was done. No trauma screen was found to be conducted on R211's admission. On 05/13/25 at 01:55 PM, interviewed the Social Services Director (SSD) and Social Services Assistant (SSA) 1 in the SSD's office. The SSD was asked if trauma screening was done on admission (04/15/24) for R211. The SSD stated there is no trauma screen form that is utilized. The SSD stated that a psychosocial assessment,	F 699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	Continued From page 75 which has one question about trauma, is completed during the facility's welcome meeting. SSA1 added that the welcome meeting occurs a day or two after the resident's admission. The SSD presented the resident's psychosocial assessment with a completion date of 06/22/24, which was more than 2 months after the resident's admission. SSA1 stated that a Social Services "Life Event Checklist" should have also been completed after the welcome meeting with the resident/responsible party. This checklist assists in creating a TIC care plan. SSD presented a completed checklist with a former SSD's signature dated 05/04/24. The responses to all 17 questions which asked about difficult or stressful things that sometimes happen to people were all marked, "e. Doesn't apply" and was not completed timely. On 05/14/25 at 09:07 AM, received the staff training log for TIC. Only the SSD was noted to have a date of completion. No completion dates for other social services staff (SSA1, SSA2, and SSA3) were found. On 05/15/25 at 10:49 AM, the SSD confirmed that SSA1, SSA2 and SSA3 did not complete the training as of this date and time.	F 699		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health	F 740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 76	F 740		

encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure the necessary behavioral health care services that were person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety were provided for one Resident (R) 201 of four residents in the sample. This deficient practice has the potential to affect all of the residents residing on the unit.

Findings include:

Cross reference to F641

Interview on 05/12/25 at 12:30 PM with R2 and R103 on the Piikoi 2 dining area. R2 referred to R201 and said to the surveyor that she was upset because sometimes R201 goes into other people's rooms and takes their food. Sometimes she will take food off trays from the kitchen carts that sit in the hallway. R2 added that R201 sometimes drinks water from the pitcher on the tables in the hallway and dining area, because no one monitors her. Once she went into another resident's room, hit the resident and took her banana away from her. Later that resident told me that she feared R210, so she gave her the banana. We have complained about her to the staff, and they just let her go, make excuses for her and never do anything about it. She needs more monitoring from the staff, but they are busy. R2 said, she really needs a 1:1 staff to stay with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 77	F 740		

her and R103 agreed. R103 said, R201 has been here for a long time, and they let her go, they tell us we must endure it. They say we can't control people's behavior. Sometimes she hits other residents. She opened the food cart and takes the food from the trays. She's very mobile, she can't speak. I watched her take R158's food. The head nurse was sitting right there and watched her do it. R201 is aggressive if she doesn't get her way. R201 walked down the hallway and R2 gestured toward her, gestured with a nod and said that's her, she's the one who steals the food.

Observation on 05/12/25 at 12:55 PM. R201 observed to wander in the hallway on Piikoi 2. She was standing near the carts while the resident's trays were being passed.

Observation on 05/13/25 at 09:07 AM. R201 walked briskly on Piikoi 2 from her room at the end of the hall to the nurse's station. She was alone.

On 05/13/25 in the morning, R201 was observed on the Lewalani unit 2 by another surveyor from the team. She came up behind the surveyor unexpectedly and surprised the surveyor. She wasn't assisted or supervised.

Care plan reviewed on 05/13/25. Behavior. The resident tends to wander on the hallway or even go to the other floors...Resident has behavior of looking for food, trying to go into the kichenette or other rooms to search for food or will take food from other residents trays if no one is watching... revision on 04/10/25. Provide supervision when resident walks along the room & hallway. Encourage her to return to her room, offer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 740	Continued From page 78	F 740		

assistance as needed, and offer toileting assistance as needed (revision on 06/27/24).

Social Services (SS) Quarterly & Annual Note dated 5/9/2025 reviewed on 05/13/25. R201 is a Resident is 75 years old, admitted to facility on 1/23/2024 with admitting diagnosis of Hemiplegia and hemiparesis after a stroke affecting her left side. R201 also has dementia, unspecified without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. R201 is on psychotropic medications.

Social services progress notes dated 05/13/25 at 16:07:38 and reviewed on 05/13/25. Writer met with resident for 1:1 psychosocial visit regarding concerns of her behavior towards staff member. Writer spoke with staff member, he verbalized he has no issues with the resident, and he understands her condition. Staff member declined to escalate concern. No further questions currently.

Social Services progress note dated 5/13/2025 at 15:41:05 and reviewed on 05/13/25. Writer met with resident regarding concern about her taking food from other residents and informed residents she is not allowed to take other resident food. Resident was agreeable. No further questions currently. Writer will follow up as needed.

Observation on 05/14/25 at 01:37 PM at the Piikoi 2 nurse's station. R201 walked briskly down the hall toward the nurse's station and turned right toward the Lewalani unit. A moment later staff came quickly around the corner and called out to R201 to come back. A few minutes later she was observed to walk back toward her room with the staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 79 Observation on 05/14/25 at 04:58 PM at the Piikoi 2 nurse's station. R201 was observed to wander in the hallway. She walked up to R199 who was sitting in front of the nurse's station in his wheelchair eating potato chips. Without asking or being offered, R201 put her hand in the bag of chips and put them into her mouth. The R199 made a grumbling noise toward R201 and moved the bag of chips away. R201 gestured to smirk and point her finger at R199. Certified Nurse Aides (CNAs) 98 and 100 were present and said to R201, stop, be nice! R201 continued to point her finger at the resident and make guttural noises to R199 while the staff observed. Interview with the Social Services Director (SSD) in the social services office on 05/15/25 at 10:10 AM. The surveyor asked her if she knew what the underlying causes of R201's behavior was. She responded that she wasn't sure why R201 tries to grab the food. During activities when music is playing, she is very calm. She likes music. When she takes food, we call her son, and he talks to her. Staff here try to redirect her. The surveyor asked her if she thinks R201 understands when staff tell her not to do something. She said yes, I think she does. When asked if she thinks R201 needs more supervision she said, yes, because it is upsetting to the other residents when she takes their food. Interview with Licensed Practice Nurse (LPN) 2 on 05/15/25 at 10:24 AM. The surveyor asked if she was familiar with R201. LPN2 said, before R201 was on another floor. Her level of function was more declined. She had a Gastrostomy (G)-Tube and after they took the G-tube out she got better, then she started walking and I think	F 740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 80	F 740		

that's why she likes to eat so much. The staff try to redirect her when she is wandering and keep her safe. The surveyor asked LPN2 if R201 needs more supervision. LPN2 said, she's okay if she stays on the floor where we can supervise her. If she goes on the elevator, or goes downstairs, the wander guard will alarm. The surveyor asked if the wander Guard works. LPN2 said yes, it works. The surveyor asked if it upsets the other residents when she tries to take their food, she said, yes, they complain about her. We talk to them and try to explain that she has theses behavior problems. We try to help them understand.

Interview with the Social Services Assistant (SSA) 1 in the social services office on 05/15/25 at 11:30 AM. The surveyor asked SSA1 if she knows what are the underlying causes for her behavior? (e.g., history of trauma, mental disorder) of the resident's behavioral expressions or indications of distress, specifically included in the care plan. SS1 said, that she wasn't sure of any underlying causes for the behavior. Social services staff talk with the families and the resident about any behaviors. The Social Services Director is the one responsible to send a referral to the Psychiatrist. Since there is not a Social Services Director, the referral will be made by the Assistant Director of Nursing (ADON) to R201's psychiatrist. The surveyor confirmed that once the referral is made, and evaluation completed the recommendations from the psychiatrist would be implemented into the plan of care.
The surveyor asked SSA1 if R201 is safe on the unit and in the facility. Are other residents on the unit safe with her wandering on the unit. The SSA1 said, I think she needs more supervision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 81 Requested a copy of the most recent psychiatric evaluation (the last report was dated 2022) from the Assistant Director of Nursing (ADON) on 05/15/25 at 01:07 PM. Telephone call with the Medical Director on 05/15/25 at 01:45 PM. The surveyor referenced R201 and asked the medical director if psychiatric services are being provided to R201 and if not, how is the referral made for the resident. The Medical Director said, it takes a while for a referral. Referrals must go through the attending. Sometimes the practitioner is working with the MD then the facility does the arranging. Usually, the nurse speaks to the team, sometimes the social worker and the team. I can ask them to prioritize this if it is needed. We would be discussing R210s behavior at the quarterly psychotropic meetings. Behavioral Health Services Medically related social services policy dated 03/2023 reviewed on 05/15/25. Policy: The facility provides medically related social services to support each resident to attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. Guidelines: Social Services department advocates and assists resident(s) in the assertion of their rights within the facility by 5. Making referrals and obtaining needed services from outside entities; 8. Assisting with arrangements for needed mental and psychosocial counseling service as ordered.	F 740		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 82 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to 1) Ensure the accurate administering of all drugs to meet the needs of 1 Resident (R) 9 of 36 residents sampled. R9 was given medications more than 2 hours early without consideration of safety/efficacy and 2) Assure licensed staff signed the narcotic log each	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 83	F 755		

time it was reconciled. The deficient practices placed R9 at risk of adverse effects related to unsafe medication administration practices and put other residents at risk for drug diversion.

Findings include:

1) Cross-reference to F842 Resident Records - Identifiable Information. Despite intentionally giving her medication more than two hours early, the Registered Nurse documented it as being given on time.

Resident (R)9 is an 89-year-old female admitted on 04/25/23 for long-term care. On 05/12/25 at 08:52 AM, observation made while at the bedside of R9. Observed at least six different medications (tablets and capsules) at the edge of the bedside table in front of her. Attempted to ask R9 about the medications but she did not respond verbally to questions, only smiled.

On 05/12/25 at 08:54 AM, called Registered Nurse (RN)3 into the room for a concurrent interview and observation. RN3 confirmed that the medications on the bedside table appeared to be R9's morning medications. RN3 explained that her shift began at 07:00 AM, and when she arrived on the unit, RN5 (a night shift nurse) informed her that he had already administered morning medications to R9. During a concurrent review of R9's Medication Administration Record (MAR), RN3 confirmed that the medications on R9's bedside table were due at 09:00 AM. RN3 agreed that meant the medications were left more than two hours before they were due. In addition, RN3 commented that the blood pressure medications due at 09:00 AM had parameters that needed to be met before they could be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 84	F 755		

administered safely. RN3 explained this was another reason the medications should not have been left at the bedside or given so early.

Review of the facility's policy and procedure, Medication Administration, last revised on 03/01/23, revealed the following:

"Obtain and record vital signs, when applicable or per physician orders."

"Administer within 60 minutes prior to or after scheduled time ..."

"Observe resident consumption of medication."

Review of the MAR noted the following medications with parameters given by RN5 more than 2 hours early included, but were not limited to:

Amlodipine (for high blood pressure) 7.5 milligrams (mg), "Hold for SBP [systolic blood pressure] less than 110mmhg [millimeters of mercury, a measurement of pressure]."

Metoprolol Succinate ER 12.5 mg for Tachycardia (elevated heart rate) and Hypertension (high blood pressure). "Hold for SBP < [less than] 110mmhg and HR [heart rate] < 60BPM [beats per minute]."

On 05/12/25 at 09:04 AM, interview was done RN5. RN5 confirmed he had given the medications due at 09:00 AM to R9 more than 2 hours early, explaining that he knew he was working an overtime shift (a second shift), and was "trying to get a head start on his [day] shift" by giving the medications out before his first shift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 85	F 755		

(the night shift) ended at 07:00 AM. RN5 reported that he gave "around 6 residents" their 09:00 AM medications before 07:00 AM. RN5 agreed he should not have given any of the medications so early. Concurrent review of R9's electronic health record (EHR) revealed that the blood pressure and heart rate taken by the Certified Nurse Aide (CNA) that morning was not put into the system until 07:39 AM. RN5 confirmed that he did not take R9's blood pressure and heart rate himself before giving her the medications. RN5 stated he used the data from the morning CNA to ensure the medications were safe to give. When asked how he could use the CNAs data when it was not entered into the EHR until after he had given the medications, RN5 stated he "checked the CNA paper [written documentation of the vital signs the CNAs take until they have the time to enter it into the EHR]." When asked what time the morning CNA's shift began, RN5 stated he did not know because he normally works the night shift.

On 05/12/25 at 09:20 AM, during an interview with RN3, who frequently serves as the Nurse Supervisor for the floor, confirmed that the morning CNAs begin their shift at 07:00 AM. RN3 agreed that it was not possible for RN5 to have used the morning CNAs data to ensure R9's medications were safe for her to take/met the parameters, as the CNAs arrived after RN5 had already given them. RN3 validated that this practice should not be happening.

On 05/15/25 at 07:27 AM, an interview was done with the Director of Nursing (DON) in her office. DON confirmed medications should not be given more than one hour before or after they are due, and that nurses should always ensure medication parameters are met prior to giving them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 86 2) On 05/14/25 at 08:14 AM checked medication cart 2 on Pensacola one with Registered Nurse (RN) 40. Reviewed med cart 2's "Narcotic Count Sheet" and found it was not fully filled out from 05/13/25. Inquired what happened and RN40 stated someone did not sign the form. Concurrent review of the Narcotic Count Sheet found the following missing: from the Day rows, On-going Nurse Signature, Count Correct Y-N and from the Afternoon row, Off-going Nurse Signature. On 05/14/25 at 10:00 AM interviewed Director of Nursing (DON) in her office. Inquired if licensed staff are to sign the Narcotic Count Sheet after they reconcile the medication with another nurse and DON confirmed this. Requested a copy of the facility's policy on Narcotic Count. Review of facility policy titled "Pharmacy Services: Reconciliation and Destruction of Controlled Substances" dated 03/203 states "Guidelines: 1. The facility will establish a system of records and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. 2. The facility determines that drug records is maintained and periodically reconciled. ..."	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 87 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that the consultant licensed pharmacist's (CLP) 1 medication regimen review (MRR) recommendations were acted upon for one of one Resident (R) 203 sampled for drug regimen review. As a result of this deficient practice the facility did not maintain the resident's	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 88	F 756		

highest practicable level of physical, mental, and psychosocial well-being and prevent or minimize potential adverse consequences related to medication therapy.

Findings include:

R203 is a 93-year-old male admitted to the facility on 02/10/24 with diagnoses of, but not limited to, spinal stenosis (spaces between the spine narrows putting pressure on the spinal cord), atrial fibrillation (the upper chambers of the heart beats chaotically and rapidly), and anxiety disorder.

On 05/14/25 at 07:18 AM, a review of R203's MRRs was conducted. One MRR recommendation was not followed-up timely and a follow-up for one MRR recommendation was unable to be located.

On 05/14/25 at 07:25 AM, a review of a MRR dated 07/26/24 noted a recommendation by CLP1 which stated, "GDR [gradual dose reduction] vs. CC [clinical contraindication] for use of Trazadone." Follow-up on the recommendation was found in the progress notes dated 09/05/24 at 07:48 AM, documented by Unit Manager (UM) 3, which stated "Provider declined Pharmacy Consultant recommendation re: GDR for Trazadone. Per MD, resident with good response, maintain current dose."

On 05/14/25 at 09:50 AM, Interviewed the Director of Nursing (DON) who stated that the Unit Managers for each resident unit are responsible to do a review within one week after the MRR is received from the consultant pharmacist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 89 On 05/14/25 at 07:35 AM. a review of a MRR dated 03/18/25 noted a recommendation by CLP1 which stated, "Resident's trazadone was discontinued. New start of Lexapro - on alert monitoring. Will discuss at our next psychotropic meeting." On 05/14/25 at 11:41 AM, the DON stated that psychotropic meetings are held monthly. The psychotropic meeting minutes for April 2025 was requested from the DON and no documentation was received.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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F 761	Continued From page 90 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: 4) On 05/12/25 at 09:54 AM observed R116 sitting in his wheelchair in front of his room. Noticed R116 had a medication cup with pills and one loose pill on his table. At this time R116's assigned nurse, RN 50 was at the medication cart, to R116's left side. RN50 was focused on who he was talking to, with his back to R116. Surveyor stood in front of R116 to observe what he was going to do with the medication. RN50 noticed surveyor in front of R116 and stated, "I have my eye on him." Once RN50 was done talking with the male person he was addressing he walked over to R116. RN50 looked down at R116 and did not say anything. Inquired of RN50 what he would do in such a situation and he said put the medication in the med cart. RN50 picked up the medication cup and started to walk away. Surveyor stopped RN50 and let him know there was a loose pill on R116's table. RN50 picked up the loose pill. On 05/15/25 at 01:25 PM interviewed DON in her office. Inquired how nurses are to administer medication and DON stated use the identifier such as a picture on the MAR (medication administration record), do hand hygiene before and after, provide the prescribed medication and water. Inquired if the nurse is to observe the resident take the medication and DON confirmed nurses are to observe resident's take the medication. Requested a copy of the facility Medication Administration policy. Review of facility policy "Medication	F 761		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 761	Continued From page 91	F 761		

Administration" which has a date reviewed/revised: 03/01/23 states "Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician an in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: ... 15. Observe resident consumption of medication. ..."

Based on observation, interview, record review and review of policy, the facility failed to ensure all medications used in the facility were stored, labeled, and administered in accordance with professional standards for four Residents (R) 47, 77, 162 and 116 of four sampled. This deficient practice has the potential for unsafe administration, loss and diversion of medications.

Findings include:

On 05/14/25 at 08:51 AM, the medication cart located on the Pensacola 2 Lower resident unit was checked with Registered Nurse (RN) 26. The following medication label and storage issues were found:

1) Observed a medication pack of Diazepam 10mg/2ml injectables for R47 with the narcotic count log wrapped around it and placed in the back of the locked narcotic storage compartment. RN26 stated that R47 was readmitted to the facility on 05/06/25 and the medication was not reordered. RN26 then stated that it is the responsibility of the Unit Manager to remove the medication and until then it is kept in the locked narcotic compartment and. It is endorsed to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 761	Continued From page 92 next shift but not counted. Observed a bottle of Lactulose 10gm/15ml for R47 in the bottom drawer of the medication cart stored with other residents' active medications. RN26 confirmed that this medication was not reordered on the resident's readmission (05/06/25) and should have been removed from the medication cart and placed in the designated bin for discontinued medications located in the unit's medication storage room. 2) Observed a bottle of Keppra 100mg/ml for R77 in the bottom drawer of the medication cart stored with other resident's active medications. RN26 confirmed that R77 was discharged from the facility on 05/11/25. RN26 also confirmed that this medication should have been removed from the medication cart when R77 was discharged. 3) Observed two bottles of the prescription medication Lagevrio for R162 in the medication cart. One bottle contained a pharmacy label, and one bottle had R162's name written on the outside of the bottle and no pharmacy label. RN26 confirmed that the second bottle did not contain a pharmacy label and stated that all prescription medication should contain a pharmacy label. On 05/15/25 at 07:50 AM, interviewed the Director of Nursing (DON) in her office. The DON stated the following: 1. The Unit Manager is responsible to remove discontinued narcotics from the medication cart weekly; 2. R47's Diazepam should have been counted while being stored in the locked narcotic compartment and should have been removed and disposed of with two nurses; 3. For discontinued non-controlled	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

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F 761	Continued From page 93 medications or if a resident is discharged, non-controlled medications should be removed from the medication cart and disposed of by the next day. If a resident is admitted to the hospital, the resident's non-controlled medications should be removed from the medication cart and stored in the unit's medication room for seven days and then disposed.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and review of policy, the facility failed to accommodate one Resident (R)250, of four residents sampled, preference of food and drink. As a result of this deficiency, R250 did not like the food and/or drink provided by the facility and would not eat it or would have other food, from outside the facility, brought in. Findings include: R250 was admitted to the facility on 04/09/25 with diagnosis including Diabetes, End Stage Renal Disease, Hemodialysis, Heart Failure, High Cholesterol.	F 806		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

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F 806	Continued From page 94 Observation on 05/12/25 at 01:45 PM, R250 was in the dining room eating outside food with family member. R250 said he did not like what was being served that day and preferred food from outside. Further inquiry revealed R250 had been requesting turkey sandwich with cheese for lunch, tea (instead of milk) and dry cereal for breakfast for several weeks. The request was not being followed and since then R250 would not eat causing him to feel malnourished and weak. Staff interview on 05/14/25 at 02:00 PM, Staff Nurse (Nurse)15 said R250 originally was on a restricted diet but signed a waiver allowing him to eat any preferred foods. Nurse15 revealed that there was constant miscommunication with the kitchen, and having the diet waiver, so the preferred foods were not being allowed. Staff interview on 05/14/25 at 02:05 PM, Food Services Director (FSD) acknowledged that there was miscommunication with the kitchen and the diet waiver. FSD later met with R250 to have his food preferences clarified. Review of facility policy on Food and Nutrition Services, Food and Drink read; Purpose, to provide residents with food and drink that is nutritive, appealing and meets their needs. Policy, the facility will prepare food and drink in methods that conserve nutritive value, flavor and appearance. Food and drink will be palatable, attractive and at a safe, appetizing temperature. The food and drinks will be prepared in a form designed to meet the individual needs, including accommodation for allergies, intolerances and preferences, according to their assessment and care plan ... Guidelines ... If a resident is unable	F 806		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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F 806	Continued From page 95 to eat a menu item due to allergies, intolerances or preferences, the facility will provide an alternative, including therapeutic textures, of similar nutritive value that is consistent with the usual food items provided by the facility. Drinks, water and other liquids, will be provided to the residents according to their needs, including the need for thickened liquids and preferences in sufficient quantities to maintain resident hydration. Items which become liquid at room temperature are included when considering liquid intake.	F 806		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store food in accordance with	F 812		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 812	Continued From page 96	F 812		

professional standards for food service safety. The deficient practice placed the residents residing on the unit at a potential risk for illness.

Findings include:

Observation with the Restorative Nurse Aide (RNA) 40 on 05/15/25 at 10:42 AM in the kitchenette on Piikoi 2. One container with food inside was labeled with a name and did not have a date. The second container that was found in the refrigerator was labeled with Resident (R) 52s name and room number and a date of 05/08/25. The surveyor asked RNA40 what the process is for storing the residents food in the refrigerator and how long is it kept. RNA40 said we write the residents name, date and room number on the package. It should be thrown out after three days. The surveyor showed her the food items that were not dated and the one dated for 05/08/25. She said, yeah, I will check with the resident. The surveyor asked her if it should be discarded, and she agreed. The surveyor confirmed the findings with Licensed Practice Nurse (LPN) 2 and Registered Nurse (RN) 55 who were sitting at the Piikoi 2 nurses station.

Interview on 05/15/25 at 11:47 AM with Kitchen staff (KS) 5. The surveyor asked who is responsible for maintaining the nourishment refrigerators on each unit. KS5 stated that maintenance of the refrigerators and food from the kitchen that is placed in the refrigerator is the responsiblity of the kitchen. The food that is stored for a resident that is either brought in from outside or placed after the meal is the responsibility of the nursing staff. They are supposed to label the food with the residents name, room number and time. It should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

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F 812	Continued From page 97 discarded after three days. Dietary services resident foods from non-facility sources policy 01/2023 reviewed. Intent: To maintain outside food, which is brought in for residents, in a safe manner. Guidelines: Food which is brought in from the outside for a resident will be labeled with the resident's name, room number and date. It will be stored in a refrigerator specifically designated for residents. Facility did not provide a policy on how long food items will be stored in the refirigerator until discarded.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential	F 842		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 842	Continued From page 98 all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 99 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain medical records on one Resident (R) 9, of 36 residents sampled that were accurately documented, in accordance with accepted professional standards and practices. Findings include: Cross-reference to F755 Pharmacy Services/Procedures/Pharmacist/Records. Although giving Resident (R)9 her 09:00 AM medications more than 2 hours early, Registered Nurse (RN)5 documented that he gave them on time. On 05/12/25 at 08:52 AM, observation made while at the bedside of R9. Observed at least six different medications (tablets and capsules) at the edge of the bedside table in front of her. At 08:54 AM, during an interview with RN3 at R9's bedside, RN3 confirmed that the medications on the bedside table were given by RN5 before 07:00 AM when RN3 began her shift. During a concurrent review of R9's Medication Administration Record (MAR), RN3 confirmed that the medications were due at 09:00 AM, and that RN5 had signed off/documented the medications as administered at approximately 08:50 AM. RN3, who frequently serves as the Nurse Supervisor for the floor, stated the facility practice is to administer medications no more than one hour before or after they are due, and to document medications as given immediately after	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 842	Continued From page 100 giving them. On 05/12/25 at 09:04 AM, an interview was done with RN5. RN5 confirmed he had given R9 her medications more than 2 hours early and did not document them as given until approximately 08:50 AM, which was 10 minutes before they were due. RN5 stated he did not "get around" to documenting the medications as given until then. After further questioning, RN5 confirmed that the electronic health record (EHR) system does not allow documentation of medication administration more than one hour before it is due, so there is no way he could have documented the medications as given when he gave them. RN5 acknowledged the documentation was inaccurate and did not align with facility and nursing standards. On 05/15/25 at 07:27 AM, an interview was done with the Director of Nursing (DON) in her office. DON confirmed medications should not be given more than one hour before or after they are due, and that documentation of medication administration should occur immediately after they are given. DON agreed that RN5's documentation was inaccurate and misleading, making it appear as if the medications were given on time, when they were not.	F 842		
F 847 SS=E	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.	F 847		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 847	Continued From page 101 §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees,	F 847		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 847	Continued From page 102	F 847		

and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k).
This REQUIREMENT is not met as evidenced by:
Based on resident/representative interviews, staff interview, record review and review of policy, the facility failed to ensure that three Residents (R)9, 54, 140 of three residents sampled understood the Binding Arbitration Agreement. As a result of this deficiency, R9, 54 and 140 did not fully understand the details of the Agreement.

Findings include:

Interview with R9's Family Representative on 05/14/25 at 01:30 PM, stated that he did not remember signing the Binding Arbitration Agreement and did not know what the Agreement was about. Family Representative said there were a lot of admission forms to sign and it was difficult to know what they were all about.

R54 interview on 05/14/25 at 01:15 PM, stated that she signed all admission papers but did not remember the discussion of the Binding Arbitration Agreement. R54 was not familiar with any details of the Agreement and revealed that she would not have signed the Agreement had she known that she was waiving her right to a traditional court trial.

R140 interview on 05/14/25 at 12:55 PM, stated that he did not remember signing the Binding Arbitration Agreement. Also, did not know what the Agreement was about and just said that it did not matter because he did not have any issues with the facility at the time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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

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F 847	Continued From page 103 Staff interview on 05/14/25 at 12:40 PM, Business Office Manager said the facility follows the Binding Arbitration Agreement policy during the admission process for all residents. Review of facility policy on Resident Binding Arbitration Agreements, Entering into Binding Arbitration Agreements read; Policy, to ensure residents and resident representatives are informed of the nature and implications of any proposed binding arbitration agreement and to ensure compliance with law regarding entering into binding arbitration agreements with residents. Policy, The facility will not require any resident or their representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. The facility will inform residents or their representatives of this right. The facility will ensure that: (1) an agreement to arbitrate is explained to the resident and/or representative in a form and manner that they understand, including in a language they understand; and (2) the resident or their representative acknowledges that they understand the agreement ... Guidelines ... An agreement to arbitrate should clearly explain that the resident/ representative has the right to refuse to enter into the arbitration agreement without fear of not being admitted or being transferred or discharged as a result of refusing to enter into an arbitration agreement. Should a resident/ representative elect to rescind an arbitration agreement within 30 calendar days of execution, the facility should have a process for such circumstances that is communicated to residents/ representatives ...	F 847		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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F 880	Continued From page 104 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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F 880	Continued From page 105 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 2) On 05/12/25 at 12:54 PM observed Certified Nurse Aide (CNA) 11 assist Resident (R) 56 with her lunch. CNA11 uncovered R56's food, mixed some of the food together and took a spoonful and offered it to R56. Right afterwards CNA11 left R56 and went into room 117 and retrieved a used meal tray and placed it in the cart. CNA11 returned to R56, stirred her food some more, took another spoonful and offered it to the resident which she took. CNA11 left R56 and walked down the hall to another resident and pushed the	F 880		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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F 880	Continued From page 106	F 880		

resident down the hall past R56 to help move him out of the way while a delivery was coming down the same hallway. CNA11 returned to R56, did not perform hand hygiene and proceeded to assist R56 with her lunch again by offering her more spoonful of food.

On 05/12/25 at 02:00 PM interviewed Director of Nursing (DON) in her office. Inquired if staff are to perform hand hygiene between tasks and DON confirmed staff are to perform hand hygiene between tasks. Requested a copy of facility policy on Hand Hygiene.

Review of "Hand Hygiene" policy with a revised date of 07/2024 states "Intent: To promote effective hand hygiene to reduce the incidence of healthcare associated infections. ... Common Situations that require hand hygiene ... 3. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice). ... 7. Before and after assisting a resident with meals (hand hygiene with soap and water)."

Based on observations, interviews, and record review, the facility failed to: 1) Ensure infection control measures were implemented for a resident with a catheter, 2) Perform hand hygiene between tasks, 3) Perform hand hygiene after doffing personal protective equipment (PPE), 4) Appropriately change or store respiratory care equipment, 5) Timely test residents who had close contact or exposed to residents infected with Covid-19 (SARS-CoV-2) and 6) Wear proper PPE for a resident on contact precautions. As a result of these deficient practices residents are at an increased risk for the spread of infection(s) to other residents in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 107 Findings include: 1) On 05/12/25 at 09:13 AM, entered Resident (R) 530's room. Observed R530's catheter bag on the floor, partially covered by the privacy bag. Conducted an interview with Registered Nurse (RN) 81 regarding the observation of R530's catheter bag partially covered and in direct contact with the ground. RN81 confirmed the catheter bag was partially uncovered, in direct contact with the ground, and it should have been hanging from a rail on the bed frame instead. 3) On 05/15/25 at 08:27 AM, CNA32 was observed walking out of room 205, designated for transmission-based precautions (TBP), on the Pensacola 2 resident unit with full PPE on (gloves, gown, N-95 respirator and face shield). After leaving the room, CNA32 doffed all off the PPE she was wearing outside of the room, reached into the clean PPE supply cart for a clean procedural mask, and then proceeded to the resident meal tray storage cart without sanitizing her hands. Upon interview, CNA32 acknowledged that she should have taken off the gloves and gown inside of room 205 and washed her hands before leaving the room. She also confirmed that she did not sanitize her hands after removing her face shield and N95 respirator outside of the room and before reaching into the clean PPE supply cart for a procedure mask. On 05/15/25 at 08:43 AM, CNA33 was outside of room 209, designated for TBP, on the Pensacola 2 resident unit. After leaving the room, she was observed doffing her face shield and N95 respirator outside of the room, reached into the clean PPE supply cart for a clean procedural	F 880		

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	125011	A. BUILDING _____ B. WING _____	05/15/2025

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HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

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F 880	Continued From page 108	F 880		

mask, and then proceeded to the resident meal tray storage cart without sanitizing her hands. CNA33 confirmed that she should have sanitized her hands after removing her face shield and N95 respirator outside of the room and before reaching into the clean PPE supply cart for a procedure mask.

On 05/15/25 at 08:49 AM, CNA34 was outside of room 202, designated for TBP, on the Pensacola 2 resident unit. After leaving the room, she was observed doffing her face shield and N95 respirator outside of the room, and reached into the clean PPE supply cart for a clean procedural mask without sanitizing her hands. CNA34 confirmed that she should have sanitized her hands after removing her face shield and N95 respirator outside of the room and before reaching into the clean PPE supply cart for a procedure mask.

A facility policy titled, "Hand Hygiene" stated, "Common situations that require hand hygiene ...5. Before and after entering transmission-based precaution areas. 6. Before and after eating or handling food."

4) On 05/13/25 at 08:04 AM, observed R162's suction machine tubing with a labeled date of "5/5". The attached Yankaeur suction catheter was not dated and placed uncovered next to incontinence supply products in the top drawer of R162's bedside cabinet.

On 05/13/25 at 02:35 PM, interviewed the Infection Preventionist (IP) in R162's room. The IP confirmed the "5/5" date on the suction machine tubing and defined it as 05/05/25. She also confirmed the placement of the uncovered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

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F 880	Continued From page 109	F 880		

Yankaeur suction catheter next to incontinence supply products in R162's bedside cabinet drawer and stated that was not correct.

On 05/13/25 at 03:15 PM, the IP stated that she verified suction/tubing cannisters should be changed every 7 days. The Yankaeur suction catheter should be changed every 24 hours.

On 05/14/25 at 10:40 AM, a facility policy titled, "Respiratory Equipment Management Policy" with a revised date of 01/15/25 stated, "Suction catheters and Yankauer tips should be changed every 24 hours ..." No change time for schedule for suction machine tubing and cannister was noted in the policy.

5) On 05/14/25 at 01:12 PM, a facility policy titled, "Covid-19" with a revision date of 08/2024 stated, "Asymptomatic residents ...who experience close contact with someone with COVID infection; first test occurs 24 hours following close contact exposure. Testing is repeated with two additional viral tests obtained 48 hours apart, on days 3 and 5."

On 05/15/25 at 01:26 PM, the IP stated that all resident rooms on the Pensacola 2 Lower resident unit (rooms 201-209), except for room 204, were on TBP because of residents testing positive for Covid-19 (SARS-CoV-2). The line listing of resident testing for Covid-19 was reviewed with the IP and revealed that testing was not done according to the time frames as listed above for Residents (R) 10, R40, and R 90:

R10's first Covid-19 test was done on 05/13/25 and should have been completed on 05/09/25 due to roommate R3 testing Covid-19 positive on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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F 880	Continued From page 110	F 880		

05/08/25.
R40's first Covid-19 test was done on 05/13/25 and should have been completed on 05/08/25 due to roommate R77 testing Covid-19 positive on 05/07/25.
R90's first Covid-19 test was completed on 05/10/25 and should have been completed on 05/09/25 due to roommate R3 testing Covid-19 positive on 05/08/25.

6) On 05/12/25 08:20 AM, observed CNA1 assisting R330, (who is on contact precautions) with breakfast and not wearing a gown.

On 05/12/25 08:30 AM, interview with CNA1 completed. When asked what PPE was needed for R330, CNA1 stated she was not sure. Surveyor reviewed the contact precaution PPE signage (posted in front of the R330's room) with CNA1 and CNA1 verbalized that she should be wearing a gown. CNA1 stated wearing the proper PPE prevents the spread of infection.

Concurrent interview with RN1 noted that for residents who are contact precautions, the CNAs should be wearing gown, gloves, mask, even when assisting the residents with meals to prevent infection.

On 05/14/25 at 11:45 AM, interview with Director of Nursing completed. DON confirmed that CNAs and other staff should be using the contact precautions PPE to prevent the spread of infections.

Review of the facility's "Contact Precautions" required PPE, it notes: "gloves and gown (don before room entry, don off before room exit ...face protection may also be needed if performing

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HALE NANI REHABILITATION AND NURSING CENTER	1677 PENSACOLA STREET HONOLULU, HI 96822

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F 880	Continued From page 111 activity with risk of splash or spray)"	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain the following equipment in safe operating condition: 1) medication refrigerator, and 2) medication refrigerator thermometer. This deficient practice puts residents who are prescribed medications that needs refrigeration at risk for receiving ineffective medications and unexpected reactions. Findings include: 1) On 05/14/25 at 08:23 AM, conducted an inspection of the Pensacola third floor medication storage room. Observed the freezer of the medication refrigerator was completely frozen through with ice. A clear plastic bag with an object was frozen into the ice and unable to identify the contents stored in the bag. Registered Nurse (RN) 81 was present and confirmed the freezer needs to be defrosted and was also unable to identify the content of the frozen bag. 2) On 05/14/25 at 08:30 AM, walkthrough of the medication storage room on Piikoi 1 completed with RN2. Observed thermometer temperature setting for the medication refrigerator at 60 degrees. The refrigerator contained IV (intravenous) antibiotics, insulin, and immunization vials. The recommended	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 908	Continued From page 112 temperature on the facility's log noted it should be between 36-46 degrees. The previous days temperature setting logged by staff where within the recommended temperature settings. RN2 noted that it maybe hotter because there are too many medications in the fridge and the staff must have been opening it too much. When RN2 was asked what the facility's process is if the refrigerator temperature setting is not between the recommended range, RN2 stated that she would check the temperature setting again in a few hours and call either the Unit Manager (UM) or Maintenance Assistance (MA)1 if the temperature is still not within the recommeded setting. Surveryor encouraged RN2 to call MA1 to resolve issue right away to ensure medications do not lose their efficacy. On 05/14/25 at 08:50 AM, observed MA1 troubleshooting refrigerator. MA1 changed the refrigerator setting colder. When asked how often the refrigerators and thermometers are checked and maintained, MA1 stated there is no set schedule and will address any issues as it is reported by the staff. MA1 stated there has not been any previous reports of the thermometer being broken until today. On 05/14/25 at 11:45 AM, interview with Director of Nursing (DON) completed. DON confirmed that it is important to keep thermometers in working order to ensure accurate temperatures are maintained and to keep the efficacy of the refrigerated medications. Review of the facility's "Medication Storage" Policy, in the "Procedures" section, it notes: 17."Medication storage conditions are monitored on a regular basis as a random quality assurance	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125011	A. BUILDING _____ B. WING _____	05/15/2025

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F 908	Continued From page 113 ("QA") check ..."	F 908		