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	04/25/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interviews and record review the facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) at least two days before the end of services covered by Medicare for 1 of 3 residents (Resident (R) 11) sampled for discharge notification. This deficient practice did not allow R11 and responsible party the right to file an immediate, independent medical review (appeal) of the decision to end Medicare services and did not allow R11 and responsible party time to make decisions regarding future care. Findings include: On 04/22/25, the State Agency (SA) investigated a complaint, for ASPEN Complaints/Incidents Tracking System (ACTS) #11610. On 04/22/25 at 08:08 AM, interviewed R11's family member (FM) 1 who was listed on the facility's admission record as the responsible party. FM1 stated that he received the Notice of Medicare Non-Coverage (NOMNC) via email on 04/08/25 stating that services would end on 04/08/25. On 04/22/25 at 02:50 PM, interviewed the Social Services Director (SSD) and Social Services Assistant (SSA) 1, in the SSD's office. A concurrent review of the following: 1) 04/04/25 08:21 AM social services note; 2) NOMNC issued to FM1 via email on 04/08/25; 3) and the NOMNC in R11's electronic medical record (EHR) was done. SSD confirmed that the NOMNC should be issued at least 3-4 days before the end of services covered by Medicare, and was not. SSA1 stated that the progress noted dated 04/04/25 was in error and should have been dated 04/08/25 because that is when the notice was issued. A review of the facility's policy titled, Resident Rights: Medicaid/Medicare Coverage/Liability Notice with a date of 03/2023, stated under the Guidelines section, 12. The facility will issue a NOMNC when: a. At least two days before the end of Medicare Part A stay .

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from abuse, specifically resident-to-resident physical abuse, for 9 of 9 residents (Residents (R)10, R7, R8, R3, R1, R2, R4, R5, and R6) sampled for this type of abuse. The facility failed to provide sufficient protection to prevent resident-to- resident abuse from occurring or recurring once aware of aggressive behaviors. As a result of this deficient practice, at least one resident (R10) sustained physical injuries and experienced pain related to those injuries. In addition, given that R10 has both communication and cognitive barriers, the psychosocial harm and potential for negative effects as a result of this deficient practice cannot be fully determined. Findings include: 1) On 02/24/25 at 03:07 PM, the State Agency (SA) received a facility-reported incident (FRI) for ASPEN Complaints/Incidents Tracking System (ACTS) #11519, documenting an allegation of resident-to-resident abuse of Resident (R)10 by R7. On 04/22/25, the SA entered the facility to investigate the allegation. It was noted at entrance that R10 still resided in the same room as R7. The alleged victim, R10, is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. A review of R10's most recent Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/13/25 noted a Brief Interview for Mental Status (BIMS) score of 6 out of 15, reflecting a determination of severe cognitive impairment. The same MDS assessment also documents Mandarin as R10's preferred language, and as answering yes to the question regarding .need or want an interpreter to communicate with a doctor or health care staff? Under Functional Abilities and Goals, the same MDS assessment documents R10 as requiring moderate to maximal assistance for all mobility and transfer needs, including maximal assistance for sit-to-stand, with an inability to walk at least 10 feet. The alleged perpetrator, R7, is a [AGE] year-old male, admitted on [DATE], for long-term care. A review of R7's most recent MDS assessment with an ARD of 02/07/25 noted a BIMS score of 8 out of 15, reflecting a determination of moderate cognitive impairment. Under Functional Abilities and Goals, the same MDS assessment documents R7 as requiring supervision or touching assistance for all mobility and transfer needs and includes an ability to walk at least 50 feet. Review of R7's comprehensive care plan (CP) revealed the following Focus topic (problem) initiated on 12/05/23: BEHAVIOR The resident has potential to be physically (hitting) and verbally aggressive r/t [related to] cognitive deficit, Poor impulse control. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's investigation noted the witness statement from the first staff member on the scene of the 02/24/25 incident, Unit Manager (UM)1, documented the following after finding R10 on the floor: Resident [R10] was agitated . showing me his arms . [with] purplish discoloration . seemed upset continue to point to his arms . In a separate witness statement written on the same day by UM1, noted the following regarding R7: . sitting at the edge of his bed, holding a back scratcher . I asked him [R7] what happened and he said, I was whacking the bottle that he was holding on his [R10's] hand . In her witness statements, UM1 also documented that she immediately called for Physical Therapist (PT)1 who she saw across the hall, to come in and assist her in getting R10 up off the floor. Review of R10's electronic health record (EHR) revealed no progress note documenting the incident by UM1, despite being the initial staff member on the scene. Per the facility, UM1 was unavailable for interview by the SA as she was on leave. Further review of R10's EHR revealed the following documentation of the incident in a 02/24/25 progress note at 03:12 PM by Registered Nurse (RN)3: At around 11:45am [sic], resident [R10] was found lying on the floor . immediately assisted back to bed, assessed, and was transferred to his wheelchair . Noted redness in both arms and right jaw below the ear. He said during the telephone call with interpreter that he has pain at the right and left arms and to his neck as well. Ice pack applied to his right jaw . Resident's granddaughter . was able to speak w/ [with] her grandfather . saying that he got hit on the face by the roommate when he woke up. Per the facility, RN3 was also unavailable for interview by the SA. On 04/23/25 at 11:10 AM an interview was done with the Administrator in her office. When asked why the two residents still resided in the same room within several feet of each other, Administrator answered that both residents had refused to be moved. Asked if risks versus benefits were discussed in Mandarin with R10 when refusal was obtained. Administrator responded that if an interpreter were used it would be documented in the progress note. Concurrent review of the progress note documenting R10's refusal to move rooms confirmed no documentation that an interpreter was used. Requested documentation from facility that offer to move rooms had been explained to R10 and his responsible party in a way that could be understood. A review of the facility's Freedom for Abuse, Neglect and Exploitation policy, last revised 03/2023, noted the following: When the facility has identified abuse, the facility should take appropriate steps to . protect residents from additional abuse immediately . Take steps to prevent further potential abuse . Under the area of Preventing and Prohibiting Abuse, the following guidelines were noted: . protect residents from harm during and after the investigation to include . Room or staff changes if necessary . On 04/23/25 at 02:55 PM, observations were made of R10 in his room. R10's bed was next to, and within 10 feet of R7's (alleged perpetrator) bed, with the privacy curtain drawn. An interview was attempted with R10, but he was not interested. Appeared withdrawn, lying flat in bed on his right side. Refused to make eye contact. Did answer two questions with OK, but refused to answer more questions. It was unclear if his reluctance was due to language barrier or other factors. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 04/25/25 at 07:45 AM, an interview was done with the Director of Nursing (DON) in her office. DON reported that the facility had moved the alleged perpetrator, R7, into a semi-private room the previous night, and that no other residents were in the room with him. On 04/25/25 at 08:35 AM, a phone interview was done with R10's resident representative/family member (FM)2. FM2 confirmed that she had spoken to R10 on the phone shortly after the incident and stated that before handing him the phone, staff told her only that R10 had thrown a cup of liquid at R7. She was not informed that R7 had struck out at her grandfather, or that he had sustained injuries. When she spoke to her grandfather, R10 was upset, denied throwing anything at R7, and told her that R7 had hit him on the face. FM2 stated she relayed this information to staff before hanging up, but not having been informed that R7 admitted to striking out at R10, she thought her grandfather was confused. FM2 explained that R10 does have dementia and sometimes has bad dreams, so she thought he had dreamed the incident with R7. When she visited her grandfather that evening, she did notice the mark on his face, but had no idea it was related to the incident with R7. At the visit, FM2 stated R10 was agitated and told her he wanted to be moved away from R7. FM2 stated she relayed this to nursing staff, and later in the week, she spoke to Social Services Assistant (SSA)1 and requested R10 be moved again. When asked if she had noticed a change in R10's behavior since the incident, FM2 stated that R10 seems very scared at times, but she is not certain why. Not having been informed of a physical altercation, she had thought it was again related to R10's dementia and bad dreams. Review of the EHR revealed that prior to R10 being moved to the bed next to R7, another resident (R8) had been in that bed, had a physical altercation with R7 on 09/15/24, and had been moved to another room as a result (see finding #2 below for ACTS# 11204). Prior to R8, another resident (R9) had also been in that bed next to R7 and had been moved to another room on 05/22/24. On 04/24/25 at 10:12 AM, an interview was done with R9 at his bedside. When asked about R7 as his roommate, R9 stated he had run-ins with R7 before when he was in that room. When asked to describe what type of run-ins he had, R9 stated, he threatened me with bodily harm. When asked if he reported the threat to staff, R9 stated staff were aware of the problem, that is why they allowed him to move rooms. Review of R9's EHR noted the following progress note by RN3 on 05/22/24 at 02:10 PM: Resident [R9] was transferred . as per management recommendation . Requested documentation of incident from DON. On 04/24/25 at 12:00 PM, DON reported that she could find no documentation of any incidents between R9 and R7. Concurrent review of the room transfer progress note was done. DON stated she had no idea what 'management recommendation' could mean, and that RN3 was unavailable for interview by the SA. DON confirmed that R9 has a BIMS of 14 out of 15, reflecting he is cognitively intact, and is known to be a reliable historian. DON could not explain why there was nothing documented about R7's threats to R9. 2) On 09/15/24 at 05:15 PM, the State Agency (SA) received the FRI for ACTS #11204, documenting a witnessed incident of resident-to-resident abuse between R8 and R7. On 04/22/25, the SA entered the facility to investigate the allegation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R8 is a [AGE] year-old male, admitted on [DATE], for long-term care. A review of R8's most recent MDS assessment with an ARD of 03/19/25 noted a BIMS score of 14 out of 15, reflecting he is cognitively intact. On 04/23/25 at 02:50 PM, an interview was done with R8 at his bedside regarding the physical altercation with R7. R8 stated he had only moved to the room for about a week before the incident with R7 occurred, describing R7 as having an attitude from the beginning, but R8 just ignored him. On 09/15/24 however, R8 stated R7 became verbally aggressive with him for no reason and that turned into both residents becoming physically aggressive with each other, with R8 throwing an empty bottle at R7 and pulling his hair, and R7 punching R8 on the forehead, leaving a bump on his head. Review of the facility's investigation packet into the incident confirmed the incident had been witnessed by two staff members who were unable to de-escalate the verbal altercation from becoming physical, and unable to keep the two residents separated. 3) The facility submitted a completed Event Report on 07/30/24 to the Office of Health Care Assurance (OHCA) regarding an alleged resident-to-resident abuse. ACTS report #11090 stated that on 07/23/24 at 03:50 PM, a Certified Nurse Aide (CNA) witnessed R2 punch R1 on the left eyebrow after a verbal altercation in the hallway. There were no visible signs of injury to R1, but he complained of pain. R1's family member was present at the facility and was notified of the incident. Review of R2's EHR revealed he was admitted to the facility on [DATE] for long-term placement. Diagnoses included but not limited to dementia with agitation, depression, restlessness and agitation and history of stimulant abuse. A review of R2's quarterly MDS with an ARD of 07/18/24 documented R2's Brief Interview of Mental Status (BIMS) at 5 indicating severe cognitive impairment. Medications included Seroquel (antipsychotic) and Mirtazapine (antidepressant). Under Progress Notes, the RN documented on 01/28/24, . Resident got upset with roommate d/t [due to] roommate's [sic] spitting on the floor/throwing juice . On 01/29/24, RN documented, . Resident noted with anger behavior today insisting to go down the elevator even if he just came back from downstairs, redirected. On 04/24/24, RN documented, . Resident calls out/yells for help if he needs assistance, and yells if staff can't attend to him right away. Review of the facility's investigative notes revealed that on 07/23/24 at 03:50 PM, R1 was sitting up in his wheelchair in the hallway and partially blocking the entryway of R2's room. R2 was also up in his wheelchair and is able to self-propel. R2 asked R1 to move so he can enter his room but R1 did not move. Both residents started yelling at each other and CNA3 heard it from inside another resident's room. CNA3 came out to investigate and witnessed R2 punch R1 on the eyebrow. CNA3 separated the two residents and immediately asked for assistance from other staff members. When R2 was asked what happened, R2 said he hit R1 in the face because R1 did not move out of the way when he asked him. 4) The facility submitted a completed Event Report on 08/06/24 to OHCA regarding an alleged resident-to-resident abuse. ACTS report #11108 stated that on 08/01/24 at 07:55 PM, R4 kicked R3 on his right upper arm as witnessed by CNA2. There were no visible signs of injury to R3, family and police were notified and R4 was moved to another unit. Review of R3's EHR was conducted. R3 was a [AGE] year-old resident admitted to the facility on [DATE] for short term rehabilitation services following right knee replacement surgery. R3 was cognitively intact and mainly spoke Arabic. (continued on next page)

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	125011	A. Building B. Wing	04/25/2025

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of R4's EHR conducted. R4 was a [AGE] year-old resident admitted on [DATE] for short term rehabilitation services. Diagnoses included but not limited to generalized weakness, history of alcohol abuse complicated by withdrawal and schizoaffective disorder. Prior to admission to the facility, R4 was living in a care home but eloped and is currently homeless. Medications included Risperidone (antipsychotic) and Lorazepam (antianxiety). Progress Notes entry dated 08/01/24 stated, At 7:55 P.M., resident kicked room mate [sic] right upper arm. He thought room mate stealing his wheelchair when room mate grabbed the wheelchair backrest part. On 04/24/25 at 06:38 AM, an interview was conducted with CNA2 at the nurse's station. CNA2 stated that R3 was in his wheelchair, and she was bringing him back to his bed which was closer to the window. R4 was sitting up in his bed which was closer to the door. R4's wheelchair was between the two beds so CNA2 asked R4 if she can move his wheelchair to give R3 more room to transfer from his wheelchair to the bed. R4 told CNA2 not to touch his wheelchair. R3 placed his hand on the backrest of R4's wheelchair in an attempt to move it. R4 then kicked R2 on his right upper arm from a sitting position on his bed. CNA2 moved R3 away from R4 and called the RN for assistance. Review of facility policy titled, Freedom from Abuse, Neglect and Exploitation stated, Purpose: to keep residents free from abuse . of any kind by any person. This includes freedom from verbal, mental, sexual, or physical abuse . Cognitive impairment or mental disorder does not preclude a resident from being abusive . Physical abuse includes, but not limited to hitting, slapping, punching, biting and kicking. On 04/25/25 at 09:30 AM, concurrent record review and interview was conducted with DON in her office. Reviewed with DON the investigation reports and witness statements for ACTS #11090 involving R2 and R1, and ACTS #11108 involving R4 and R3. Both investigation reports concluded that abuse was not substantiated. Asked DON if abuse occured based on the eyewitnesses' statements and what was documented in the progress notes, DON said, Yes, abuse should have been substantiated. 53) Review of Resident (R) 5 and R6 completed Event Report (ACTS #11159) submitted by the facility on 08/28/24 to the Office of Health Care Assurance (OHCA) noted R5 and R6 with observed verbal altercation and both alleged getting hit on the cheek by each other while in a common area for an activity event. On 04/24/25 at 09:30 AM, interviewed Recreation Aide (RA) 1 in the Activity Department. RA1 stated she remembered a verbal altercation between R5 and R6 occurring on 08/23/24 outside of the activity department near the vending machines where morning music activity took place. RA1 stated she and one other staff (RA1 and RA2) were assigned to the activity. However, during R5 and R6's verbal altercation, RA1 confirmed that she left the residents alone in the activity area to look for a co-worker for assistance. RA1 stated that she did not notify RA2 before leaving and did not know where RA2 was located at the time. RA1 acknowledged that without staff supervision, residents were left in an unsafe environment. On 04/24/25 at 11:27 AM, interviewed RA2 regarding the altercation between R5 and R6. RA2 stated she was transporting other residents and was not in the activity area during the altercation. A review of the facility policy titled, Freedom from Abuse, Neglect, and Exploitation stated, The facility will provide a safe resident environment and protect residents from abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report to law enforcement, allegations of resident-to-resident abuse that included physical assault for 3 of 5 resident-to-resident abuse investigations (ASPEN Complaints/Incidents Tracking System (ACTS) #11519, 11204, and 11090) conducted by the State Agency (SA). This deficient practice potentially compromised the thoroughness of the facility's investigations into these events and placed Residents (R)10, R8, R7, R1, and R2's safety at risk. Findings include: 1) Cross-reference to F600 (Free from Abuse and Neglect) The facility failed to protect R10 from resident-to-resident physical abuse by R7 despite identifying a history of physical aggressiveness. On 02/24/25 at 03:07 PM, the State Agency (SA) received a facility-reported incident (FRI) for ASPEN Complaints/Incidents Tracking System (ACTS) #11519, documenting an allegation of resident-to-resident abuse of Resident (R)10 by R7. On 04/22/25, the SA entered the facility to investigate the allegation. Review of the facility's Freedom for Abuse, Neglect and Exploitation policy, last revised 03/2023, noted the following: The facility will report to the State Agency and law enforcement any reasonable suspicion of a crime . Examples include, but are not limited to . assault and battery . On 04/23/25 at 11:10 AM an interview was done with the Administrator in her office. Administrator confirmed that law enforcement had not been informed of the incident because both of the residents involved had refused. When asked if residents who have a BIMS of 6 and a surrogate decision-maker are usually allowed to decide whether law enforcement should be called to report physical assault, Administrator answered that at the time of the incident, the facility would ask the residents if they wanted the police to be called, but has since been instructed by their regional office to call the police for every reportable incident, no matter what. 2) Cross-reference to F600 (Free from Abuse and Neglect) The facility failed to protect resident-to-resident physical abuse between R8 and R7 despite identifying a history of physical aggressiveness. On 09/15/24 at 05:15 PM, the State Agency (SA) received the FRI for ACTS #11204, documenting a witnessed incident of resident-to-resident abuse between R8 and R7. On 04/22/25, the SA entered the facility to investigate the allegation. On 04/23/25 at 11:10 AM an interview was done with the Administrator in her office. Administrator confirmed that law enforcement had not been informed of the incident because both of the residents involved had refused. Administrator also confirmed that the two residents had physically assaulted each other, which is a reportable crime. 3) Cross Reference to F600 (Free from Abuse and Neglect) R2 punched R1 after a verbal altercation and the facility failed to report it to law enforcement. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility submitted a completed Event Report on 07/30/24 to the Office of Health Care Assurance (OHCA) regarding an alleged resident-to-resident abuse. ACTS report #11090 stated that on 07/23/24 at 03:50 PM, a Certified Nurse Aide (CNA) witnessed R2 punch R1 on the left eyebrow after a verbal altercation in the hallway. When R2 was asked what happened, R2 said he hit R1 in the face because R1 did not move out of the way when he asked him. R1's family was at the facility and was notified of the incident. R1's family declined to pursue charges or contact the police. R2 was moved to a different room. The completed report was submitted seven days after the incident occurred. On 04/25/25 at 09:30 AM, an interview was conducted with the Director of Nursing (DON) in her office. DON acknowledged that the police were not notified of R2 punching R1. When asked why law enforcement was not notified, DON stated, We have to honor the decision of the family if they do not want the police involved.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to document and provide evidence that 2 of 5 resident-to-resident abuse investigations (ASPEN Complaints/Incidents Tracking System (ACTS) #11610 and #11159) conducted by the State Agency (SA) had been thoroughly investigated. This deficient practice potentially compromised the safety of Residents (R)10, R7, R5, and R6, and affects all residents at the facility with abuse allegations. Findings include: 1) Cross-reference to F600 (Free from Abuse and Neglect) The facility failed to obtain witness statements from all staff who responded to a resident-to-resident abuse allegation that occurred on 02/24/25 between R10 and R7. On 02/24/25 at 03:07 PM, the State Agency (SA) received a facility-reported incident (FRI) for ASPEN Complaints/Incidents Tracking System (ACTS) #11519, documenting an allegation of resident-to-resident abuse of Resident (R)10 by R7. On 04/22/25, the SA entered the facility to investigate the allegation. Review of the facility's investigation packet noted the witness statement from the first staff member on the scene of the 02/24/25 incident, Unit Manager (UM)1, documented that she immediately called for Physical Therapist (PT)1 who she saw across the hall, to come in and assist her in getting R10 up off the floor. Further review of the facility's investigation packet revealed it did not contain any witness statements obtained from PT1 as the second staff member on the scene. On 04/24/25 at 02:35 PM, an interview was done with the Administrator in her office. Administrator confirmed that a witness statement should have been obtained from PT1 since she was one of the first staff members to arrive to the incident. Administrator acknowledged that a thorough investigation into any abuse allegation should include witness statements from all staff working in the area at that time.) Review of Resident (R) 5 and R6 completed Event Report (ACTS #11159) submitted by the facility on 08/28/24 to the Office of Health Care Assurance (OHCA) noted R5 and R6 with observed verbal altercation and both alleged getting hit on the cheek by each other while in a common area for an activity event. On 04/23/25 at 02:20 PM, interviewed the DON in her office. A concurrent review of three documented staff accounts (Recreation Aide (RA)1, RA3, and Physical Therapy Aide (PTA) 1) regarding the R5 and R6 altercation was done. DON confirmed that the statements were written by the listed individuals. DON stated that she interviewed each of them but was unable to produce any documentation of her interviews. DON also stated that no interviews were done with other residents that attended the morning music activity where the altercation between R5 and R6 occurred. A review of the facility policy titled, Freedom from Abuse, Neglect, and Exploitation under the heading of INVESTIGATION stated, c. Identifying and interviewing involved person, witnesses, and others who may have knowledge .

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	125011	A. Building B. Wing	04/25/2025

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medically-related social services to 1 of 3 residents (Resident (R)10) in the sample. Specifically, the facility failed to ensure psychosocial follow-up for R10 following an allegation of physical abuse. As a result of this deficient practice, R10 was hindered in his ability to attain or maintain his highest practicable psychosocial well-being. Findings include: On 06/09/25, the State Agency (SA) entered the facility to conduct an onsite revisit to determine compliance with federal and state requirements related to deficient practices found on an earlier abbreviated survey at CFR (Code of Federal Regulations), Title 42, 483.12, Freedom from Abuse, Neglect, and Exploitation. Review of the facility's implemented plan of correction found no documentation that psychosocial follow-up had occurred for Resident (R)10, following a finding of deficient practice, at the level of harm, related to an allegation of resident-to-resident physical abuse where R10 was the alleged victim. R10 is a [AGE] year-old male admitted to the facility on [DATE] for long-term care. A review of R10's Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/13/25 noted a Brief Interview for Mental Status (BIMS) score of 6 out of 15, reflecting a determination of severe cognitive impairment. The same MDS assessment also documents Mandarin as R10's preferred language, and as answering yes to the question regarding .need or want an interpreter to communicate with a doctor or health care staff? On 06/09/25, review of R10's electronic health record (EHR) noted a progress note on 06/06/25 documenting that psychiatric follow-up in response to the 02/24/25 physical altercation with his then-roommate was still pending. Further review of the EHR revealed that on 05/13/25, Occupational Therapist (OT)1 had conducted a depression screening [PHQ-9] on R10. All answers were documented as no, reflecting a score of zero, indicating minimal to no depression. Review of OT1's accompanying progress note revealed the following: PHQ9 completed w [with] input from nursing & RNA [restorative nurse aide] as pt [R10] non English [sic] speaking. It was also noted at this time that OT1's 05/13/25 PHQ-9 was the only depression screening documented for R10 since his admission. On 06/09/25 at 03:24 PM, during an interview with Nurse Consultant (NC)1, she confirmed that there was no psychosocial follow-up done for R10 following the 02/24/25 resident-to-resident physical altercation with his former roommate. On 06/10/25 at 08:28 AM, an interview was done with OT1 regarding the depression screening she had done on 05/13/25. When asked about her usual practice when conducting a depression screening, OT1 stated she will talk to nursing staff before going in [to see the resident], to see if there is dementia, or a language barrier. If there is a language barrier, OT1 stated she will use google translate or will call family [to interpret]. During a concurrent review of her progress note on 05/13/25, OT1 confirmed she did neither for R10 despite knowledge of a language barrier. OT1 stated that she asked staff to help her complete the screening questions and confirmed that neither staff member communicated with R10 in Mandarin to do so. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/10/25 at 12:40 PM, an interview was done with Social Services Assistant (SSA)1, who had been working as an SSA at the facility for a little over a year. When asked about the process that is followed when there is an abuse allegation, SSA1 stated that she had been trained that when any abuse allegation is reported to social services (SS), they immediately initiate psychosocial follow-up with visits to both the alleged victim (AV) and alleged perpetrator (AP), but that focus is on the AV. SSA1 described psychosocial follow-up as a 3-day process where SS monitors resident(s) daily for 3 days, ensures resident safety, intervenes as appropriate, and updates the resident representative(s) as to what has occurred. During a concurrent review of R10's EHR, SSA1 confirmed there was no documentation that psychosocial follow-up had been done for R10 following the abuse allegation. On 06/10/25 at 01:33 PM, during an interview with the Administrator and Assistant Administrator, both agreed that a 72-hour psychosocial follow-up should be initiated in response to every abuse allegation. Review of the following article: [NAME], R., [NAME]-[NAME], M. A., Anetzberger, G. J., [NAME], D., & [NAME], W. (2017). The National Elder Mistreatment Study: An 8-year longitudinal study of outcomes. Journal of Elder Abuse & Neglect, 29(4), 254-269, found at https://doi.org/10.1080/08946566.2017.1365031, revealed that social support is both consistently and powerfully protective against most negative [psychosocial] outcomes.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain a medical record for 1 of 3 residents (Resident (R) 11) sampled for accurate documentation in accordance with accepted professional standards and practices. This deficient practice has the potential to affect all residents in the facility. Findings include: On 04/22/25 at 08:08 AM, interviewed R11's family member (FM) 1 who was listed on the facility's admission record as the responsible party. FM1 stated that he received the Notice of Medicare Non-Coverage (NOMNC) via email on 04/08/25 stating that services would end on 04/08/25. On 04/09/25, prior to entering the facility, State Agency (SA) received a copy of the NOMNC issued by Social Services Assistant (SSA) 1 to FM1 via email on 04/08/25. On 04/22/25 at 09:00 AM a scanned copy of the NOMNC for R11 was found in the Electronic Health Record (EHR). On this copy, additional handwritten information was noted in the Additional Information (Optional) section which stated, .issued NOMNC 4/4/25 . On 04/22/25 at 09:00 AM, during review of R11's medical record, a social service notation by SSA1, dated effective 04/04/24 at 08:21 AM and with a late entry created date of 04/08/25 08:25 AM, documented, NOMNC issued to representative. Writer went over Notice of Medicare Non-Coverage with representative . No questions at this time . On 04/22/25 at 02:50 PM, interviewed SSA1 in the Social Services Director's (SSD) office with the SSD present. A concurrent review of the following: 1) 04/04/25 08:21 AM social services note; 2) NOMNC issued to FM1 via email on 04/08/25; 3) and the NOMNC in R11's EHR was done. SSA1 confirmed that the NOMNC was issued to FM1 on 04/08/25 and not on 04/04/25 as documented in the social services note and scanned NOMNC doument located in R11's EHR.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interviews and record review, facility did not employ a qualified social worker on a full-time basis as required for a facility with more than 120 beds and this facility was licensed for 288 beds. This deficient practice has the potential to affect all residents in the facility. Findings include: On 04/23/25 at 08:53 AM, the Administrator stated that the current Social Services Director (SSD) did not have the required credentials for a social worker (minimum of bachelor's degree in social work or a bachelor's degree in a human services field). On 04/23/25 at 09:55 AM, a review of employment documentation for the social services staff was conducted. The following was noted: Social Services Assistant (SSA) 1 with a hire date of 05/30/24 had less than a year of supervised social work experience in a health care setting. A review of a listing of her previous jobs on the facility's work application reflected experience other than that as a social worker and was not in a health care setting working directly with individuals. SSA2 and SSA3 with recent hire dates of 03/20/25 and 03/27/25 respectively did not meet the definition of a qualified social worker. On 04/23/25 at 01:20 PM, interviewed the SSD and SSA1 in the SSD's office. SSD confirmed that she did not have a bachelor's degree or social work license. SSA1 confirmed that her previous work experiences, prior to being employed at the facility, was not in the capacity of a social worker in a health care setting working directly with individuals.