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	11/19/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure there was sufficient nursing staff to provide nursing and related services to meet the residents' needs safely for 6 of 9 residents (Residents 1, 2, 3, 4, 7, and 8), and 4 of 7 floors sampled. Specifically, residents were not receiving their showers or restorative nursing services as scheduled, residents were not being transferred by mechanical lift per the facility policy and protocol for safety, and a resident requiring an around-the-clock one-to-one (1:1) sitter did not consistently have one. As a result of this deficient practice, residents were placed at risk of a preventable accident/injury or decline in mobility.Findings include: 1) Resident (R) 4 is a [AGE] year-old male with a readmission date of 09/06/25 and diagnoses that include paraplegia (loss of sensation and motion in the lower part of the body), central cord syndrome (spinal cord injury affecting arms and hands), and restless leg syndrome (irresistible urge to move the legs). A Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/30/25 noted that R4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated that R4 is cognitively intact. On 11/18/25 at 10:57 AM, R4 was interviewed in his room. R4 stated he was on a restorative exercise program, conducted six time a week, where the Restorative Nurse Aide (RNA) would exercise his arms, stretch his legs, sit him at the edge of the bed, have him do foot pedaling on the exercise bike, and do sit to stand exercise using the Arjo (ambulatory support aide that can be used to safely lift the resident). R4 stated he had not gotten out of bed and exercised since the beginning of November 2025 after the Certified Nurse Aides (CNAs) schedule was changed and the RNAs were now working on the unit as CNAs due to short staffing. R4 stated he was frustrated that he could not do his exercises and complained of increased back, knee, and ankle pain, increased swelling to his legs, and felt he was weaker overall in his arms and legs. R4 asked for his blanket to be lifted where swelling to bilateral legs, from shin to foot, left leg greater than right leg, was observed. R3 is [AGE] year-old female readmitted on [DATE] with diagnoses that included quadriplegia (loss of muscle function of all four limbs and the trunk of the body) and conversion disorder with motor symptom or deficit (psychological (mind, behavior, emotions) stress is converted into involuntary motor deficits, such as weakness or loss of muscle function). A Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/02/25 noted that R3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated that R3 is cognitively intact. On 11/18/25 at 11:11 AM, R3 was interviewed in her room. R3 stated she would get her arms and legs exercised, which helped the spasms in her legs, along with assist turning side to side in bed by the RNAs six times a week. R3 stated that since the CNA schedule changed at the beginning of November 2025, the two RNAs for the unit (RNA5 and RNA6) have been working as CNAs on the unit due to short staffing. R3 stated she has not been receiving RNA services and therefore, the spasms in her back (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and legs were back again and upper body was tight. On 11/18/25 at 01:45 PM, RNA5 was interviewed in the hallway of the unit where R3 and R4 resided and stated that unit was his primary assignment. A concurrent review of the paper documentation of the RNA daily log of residents currently being provided RNA services from 11/02/25 to 11/17/25 was done. R3's last date of documented RNA service received on the log was 11/02/25. R4's last date of documented RNA service received was 11/05/25. RNA5 confirmed those dates were the last time R3 and R4 received RNA services and stated that since the CNA schedule of hours was changed on 11/02/25, the RNAs have been primarily scheduled to work in the CNA role because of short staffing. On 11/19/24 at 09:57 AM, a review of the Nursing Restorative Monthly Review, which listed the specific restorative program for R3 and R4, were both marked, Continue Present Goal/Plan and signed off by Licensed Practical Nurse (LPN) 3 on 11/15/25. 2) R1 is a [AGE] year-old female admitted to the facility in August 2015. On 11/18/25 at 01:33 PM, an interview was done with R1 at her bedside. R1 complained about short staffing of the Certified Nurse Aides (CNAs) on the floor, especially between 12:00 PM and 06:00 PM. When asked how the short staffing affects her, R1 answered that this past Saturday [11/15/25] was the first time she had received a shower in two weeks because there had not been enough CNA staff to shower her. R1 reported that she usually is showered on Tuesdays and Saturdays on what used to be the evening shift (03:00 PM to 11:30 PM), but since the changes in CNA shifts/staffing began on 11/02/25, there had not been available staff to help her shower. Review of R1's Comprehensive Care Plan (CP) noted the following regarding showers: She requires more assistance with functional mobility and self care [sic] skills. Shower 2x/week preferably on Tuesdays & Saturdays Evening Shift. Review of R1's point-of-care (POC) log for showers confirmed that since 11/02/25, R1 had received 1 of 4 showers scheduled. R2 is a [AGE] year-old male admitted to the facility in September 2020. On 11/18/25 at 01:49 PM, an interview was done with R2 at his bedside. R2 also complained about short staffing of CNAs and reported that he had not been receiving showers as he was used to. R2 stated that prior to 11/02/25, he had been scheduled for and received three showers a week, on Wednesdays, Fridays, and Sundays. Since 11/02/25 however, R2 stated that he had been showered only twice because there was rarely enough staff to complete his showers as scheduled. Review of R2's CP noted the following regarding showers: . Shower 3x/week preferably on Wednesdays, Fridays, & Saturdays Evening Shift. Review of R2's POC log for showers confirmed that since 11/02/25, R2 had received 2 of 7 showers scheduled. 3) R7 is a [AGE] year-old female admitted to the facility in July 2021. Review of R7's CP revealed the following: Transfer: The resident requires total assist from 2 staff for transfers via. mechanical lift. On 11/17/25 at 03:39 PM, observed CNA12 independently transferring R7 into bed using a mechanical lift. Concurrent interview with CNA12 confirmed that R7 is a 2-person transfer via mechanical lift. When asked why she transferred R7 by herself, CNA12 answered that there were only 3 CNAs until 06:00 PM, and explained that one CNA was showering a resident, one CNA was doing rounds checking vital signs, leaving her by herself for transfers. Interview with R7 at the time revealed that since 11/02/25, there is never 2 CNAs available at the same time to help me. Review of the facility's policy and procedure, Safe Resident Handling/Transfers, last reviewed 01/15/24, revealed the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staff members are expected to maintain compliance with safe handling/transfer practices. Resident lifting and transferring will be performed according to resident's individual plan of care. 4) R8 is a resident that requires one-to-one (1:1) around-the-clock supervision (sitter). Review of R8's Provider Orders revealed the following order since 06/18/2025, 1:1 supervision due to wandering and to meet resident's needs until alternate placement can be found. On 11/18/25 at 01:30 PM, during an interview with Registered Nurse (RN) 6, discovered that the 1:1 sitter for R8 had not shown up yet. RN6 stated that the staff member previously assigned to R8 had finished their shift at 12:30 PM. Verified through observation that there was no 1:1 sitter in R8's room. RN6 stated that R8 required a sitter due to elopement risk. 5) On 11/17/25 at 06:14 AM, observed on the PK2 floor that there were two licensed nurses, and three CNAs assigned. Concurrent interview with RN7 confirmed a census of 49 residents that RN7 stated usually meant at least 4 CNAs would be assigned. RN7 agreed that 3 CNAs were not enough to adequately meet the needs of the residents in a timely manner. On 11/17/25 at 11:37 AM, an interview was done with CNA14 on PW2. CNA14 confirmed a census of 45 residents and stated that usually there would be 6 CNAs [assigned] for day shift and 5 CNAs [assigned] for evening [shift] and night [shift]. CNA14 reported that since 11/02/25, sometimes between 12:00 PM and 06:00 PM, there was only 1 or 2 CNAs scheduled. On 11/17/25 at 12:15 PM, observed on LW1 that there was 1 CNA (CNA15) assigned to relieve the 2 CNAs getting off at 12:30 PM. Confirmed with CNA15 and RN8 that with a census of 18 residents, 1 CNA would be very difficult to meet all of their needs in a timely manner. On 11/18/25 at 04:07 PM on PW2, during an interview with RN9, confirmed that as of 03:30 PM, she was the only nurse on the floor assigned with 3 CNAs for a census of 45 residents. RN9 stated it is very difficult to work so short. RN9 added that she tries to help the CNAs but how can I when I have to also pass meds, document, and make sure residents are safe? On 11/19/25 at 09:48 AM, review of the staff schedule for Friday 11/14/25 noted that from 03:30 PM to 06:00 PM on PK2, there was 1 CNA working on the floor of 49 residents and no 1:1 sitter assigned to R8. Confirmed by interview with the Scheduler (S1) that there was 1 CNA at that time. S1 agreed that the goal is to ensure more than 1 CNA is working on any of the floors. On 11/19/25 at 11:30 PM, an interview was done with the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Chief Nursing Officer (CNO). During a concurrent review of the Letter of Understanding re [regarding] Work Load from the 2023-2025 Collective Bargaining Agreement, CNO, DON, and ADON confirmed that for the PW and PK floors, the goal is to ensure there are a minimum of 4 CNAs assigned at any given time, and for the LW floors, a minimum of 2 CNAs. On 11/19/25 at 12:50 PM, an interview was done with S1. During a concurrent review of the 11/13/25 staff schedule, S1 confirmed that there was 1 CNA on PK2 from 03:30 PM to 04:30 PM when she was joined by 1 other CNA (besides the 1:1 sitter). S1 also confirmed that there was 1 CNA on LWG that day from 03:30 PM to 06:00 PM. S1 agreed that when she makes the schedule, her goal is to ensure there is more CNA staff than that.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure its nurse staffing information was posted in a prominent place readily accessible to all residents. In addition, the facility failed to ensure the staff information that was posted met the data requirements, specifically, facility name, resident census, and the total number and actual hours worked by licensed and unlicensed staff. Findings include:On 11/17/25 at 11:53 AM, observations made on the ground floor of the main building noted a staff assignment posting on the table at the main entrance, and a copy posted near the time clock. Review of the staff posting noted it did not include the facility name, resident census, or the total number and actual hours worked by licensed and unlicensed staff. A tour of the facility later that day noted the staff assignment (still lacking the aforementioned data) was also posted by the time clocks on the first floor of the main building, and the first floor of 1 of 2 other buildings. The same observations were made during tours of the facility on 11/18/25 and 11/19/25.On 11/19/25 at 10:30 AM, an interview was done with the Administrator, the Assistant Director of Nursing (ADON), and the Chief Nursing Officer (CNO). When asked about the staff posting, the Administrator explained that the Scheduler is responsible to post the information at the start of every shift and confirmed that it is posted at the main entrance and by the time clocks. The ADON listed the location of the time clocks on the property (1 on the ground floor of the main building, and 2 on resident units) and confirmed that there were no other time clocks. When asked how the staff posting would be accessible to residents that cannot or do not leave the 5 other units on property where it is not posted, the CNO nodded and acknowledged that it is not currently posted in a prominent area accessible to those residents. On 11/19/25 at 10:50 AM, during a concurrent review of the staff posting, the Administrator agreed that it did not contain all the components to meet the requirements of a staff posting.Review of the facility's policy and procedure on Nurse Staffing Posting Information, last reviewed on 04/28/25, revealed the following: This facility's policy is to make nurse staffing information readily available in a readable format to residents, staff, and visitors at all times.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and review of the current Facility Assessment, the facility failed to review and update the assessment when there was a change to a six-hour Certified Nurse Aide (CNA) shift schedule on 11/02/25. As a result of this deficient practice, the assessment did not reflect that the facility assessed how many CNAs were needed on each shift to safely care for the needs of the residents.Findings include:On 11/17/25 at 06:15 AM, a memo posted on the wall by the main building time clock was reviewed. The memo dated 09/29/25 contained the following information:Addressed to: CNA(s) at [Facility]From: [Facility] LeadershipRegarding: Implementation of six (6) hour shift schedule for CNA(s)Content: .facility will be moving to a six (6) hours schedule for CNA(s).effective 11/2/25The new CNA schedule was listed as: 06:00 AM -12:30 PM, 12:00 PM - 06:30 PM, 06:00 PM - 12:30 AM, 12:00 AM - 06:30 [NAME] 11/17/25 at 10:25 AM, the Facility Assessment was reviewed. The Date Completed/Updated was documented as 11/17/25 and Completed By the Administrator. Page 20 of the Facility Assessment, under the section titled, Staffing Needs as per Resident Unit, did not list the staffing needs for the 4 six-hour CNA shifts implemented on 11/02/25. On 11/19/25 at 10:30 AM, the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Chief Nursing Officer (CNO) were interviewed in the Conference room located on the ground floor of the main building. The CNO stated that the facility assessment staff matrix was not updated.