STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maunalani Nursing and Rehabilitation Center	5113 Maunalani Circle Honolulu, HI 96816

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from accidents for one of three residents (Resident (R) 2) sampled for falls and one of one resident (R1) sampled for accident hazards. 1) The facility failed to ensure two trained staff members operated a mechanical lift and upon analysis, indicated human error, which lead to R2's fall from the lift. During transfer with use of a mechanical lift, the left side lift sling straps slipped off the hanger bar as R2 was lifted causing R2 to fall. As a result, R2 was hospitalized with left side rib fractures with pneumothorax (collapsed lung) requiring a pigtail chest tube placement. 2) The facility failed to ensure R1 received care consistent with her physician orders. As a result, R1's safety was compromised, and she was placed at risk of an avoidable injury and/or adverse outcome in the event of a respiratory emergency. Findings Include:1) R2 was admitted to the facility on [DATE] with diagnoses, not limited to, resolved right pneumothorax, acute respiratory failure with hypoxia, pneumonia due to Hemophilus influenza, shortness of breath, muscle weakness, and unspecified abnormalities of gait and mobility. Review of R2’s admission comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/18/25, R2 scored a 14 out of 15 (cognitively intact) during the brief interview for mental status (BIMS). In section GG, Functional Abilities and Goal, R2 is dependent in chair/bed-to-chair transfer. Review of R2’s comprehensive care plan documented “I need dependent assist (2 staff with Maxi lift) during chair/bed-to-chair transfer,” created on 06/18/25. Review of R2’s nursing notes documented on 07/25/25, “Charge nurse alerted by CNA [Certified Nurse Aide] that the patient had a fall. Immediately went to the site of incident and noted patient lying on his back to the floor…Patient [R2] described pain with movement on posterior Left rib cage…The patient moved all extremities within limits. Questioned the patient on the incident. Patient landed on left side, making contact with the metal component of the lift machine. Although the patient did not strike his head, the initial impact to his left side caused his head to bounce and hit a surface.” (continued on next page)

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
	125013	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maunalani Nursing and Rehabilitation Center	5113 Maunalani Circle Honolulu, HI 96816

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the completed event report provided to State Agency (SA) on 07/29/25 documented the 07/25/25 incident, “On the day of the incident, the resident [R2] was initially transferred from wheelchair to bed at the start of the shift. Later in the afternoon, just before dinner, the resident’s spouse requested that he be transferred back to his wheelchair in anticipation of a visitor. 2 staff members assisted with the transfer using a mechanical lift…During the lift and while maneuvering the resident toward the wheelchair, the sling supporting the upper left side of the resident’s body suddenly detached. This caused the resident to fall from the lift, landing on his left side and striking his left ribcage on the metal portion of the Maxi Lift. The resident’s right food remained partially attached to the sling, contributing to the awkward fall…The following day, the resident continued to report left-sided rib pain aggravated by movement. The physician subsequently gave an order to transfer the resident to the hospital for further evaluation…The conclusion from the maxi lift representative was the hook probably shifted out of position due to rigidity of the strap combined with resident movement upon lifting. He advised staff to pay attention to the positioning of strap at all times.” On 08/13/25 at 10:34 AM, an interview with Nurse Aide (NA) 23 was done. NA23 reported her first day of work was the day before the incident on 07/24/25. NA23 stated 07/25/25 was her second day orientating on the job and was not allowed to provide care to the residents but helped and followed orders from the CNAs training her. NA23 confirmed she was in R2’s room when he fell from the mechanical lift. CNA62 was reportedly training her on how to use the lift, NA23 was at the end of the bed, on the side, and CNA62 was hooking the sling straps onto the lift with R2 positioned in the sling. NA23 reportedly remembers CNA62 tell her that she checks and double checks everything, pulled down the straps to make sure it was strong, then asked her to hold the remote and press the up button. R2 went up and NA23 stated, “I went blank and then saw him go on the floor.” NA23 confirmed, CNA62 and her were the only staff in the room operating the lift, she was orientating and only there to observe and not position or provide care. On 08/13/25 at 12:06 PM, an interview with CNA62 was done. CNA62 confirmed with NA23 present, she attempted to transfer R2 from bed to wheelchair with the mechanical lift. CNA62 reported, at approximately 05:00 PM, R2’s wife asked staff to get resident up from bed because he will have a visitor over to eat with him at the lanai. CNA62 stated they put the lift straps on the hook and started with the straps closest to the head and ended with the straps closest to the legs. While putting the straps on, CNA62 reportedly explained to NA23 where to hook the straps, to double check, and to never operate the lift alone because “…something can happen.” Then they started lifting R2 up and off the bed, his position looked good, and he was straight, then when they were ready to set up the wheelchair, R2 slipped off the sling and “…fell down from the Hoyer lift…I noticed the red plastic stopper part flipped outward…” CNA62 reported after the incident she received training from Vendor 1 (V1) and he demonstrated the straps in the right position, it was correctly put on, but the straps came off, V1 reportedly “… said we are supposed to hold the strap down…” before lifting the residents. On 08/13/25 at 01:08 PM, an interview with Maintenance Manager (MM) was done. MM reported the mechanical lift vendors came to the facility after the incident and inspected the lifts, including the one used by R2 when he fell, and found nothing wrong with the equipment. MM reported he did not keep a log that the lifts were periodically inspected but just did visual checks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maunalani Nursing and Rehabilitation Center	5113 Maunalani Circle Honolulu, HI 96816

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 08/13/25 at 01:13 PM, an interview with V1 was done. V1 confirmed he came to the facility on [DATE] along with V2, re-training staff on using the lift and proper sling strap placement and inspected the lift that was used and found it to be in working condition, no visual damage, and no mechanical failure. For the red plastic tab/clip to invert, it would require a lot of weight, and the red tabs were not meant to hold weight. V1 described the incident to be a “user error” versus “mechanical error.” V1 reported, while providing training, the facility described to him what happened when R2 fell, he attempted to replicate what was described and stated “I don’t know if she [CNA62] wasn’t aware and not paying attention, but the plastic clip doesn’t pop on its own…no one noticed it was not fully seated in the hook…I think they attached it correctly…” but when R2 was seated not putting pressure to the straps the straps would have slack and “…sometime in between the slack was pulled and moved out of place while R2 was lifted, it pulled on the red tab and came off the carry bar.” V1 stressed the importance of paying attention when lifting a resident during the training to ensure the straps do not move out of place. Review of a letter sent to the facility by V1 regarding R2's incident on 07/25/25, dated 07/28/25. “Per staff, the resident was being moved from bed to wheelchair with an… [mechanical lift] …and loop-style sling on 7/25/25. Two staff members assisted with the transfer using the lift. Staff reported that the sling strap inverted the hanger strap lock---a non-load-bearing component---resulting in the strap detaching from the hanger bar hook. This caused the resident to fall onto his left side, striking the base of the lift, with his right leg partially remaining in the sling. The lift was promptly removed for inspection. Upon inspection on 7/28/25 by…[V1] … (authorized distributor representative) and…[V2] …(distributor service manager) the lift was found to be in proper working condition. The hanger bar and hanger strap locks were intact without any visual defects. Following the incident, staff received re-education on proper sling strap placement, including reminders: 1. The hanger strap locked is not load-bearing 2. Ensure straps are fully seated in hooks 3. Best practice is to attach shoulder straps before leg straps. 4. Straps may shift until the sling is fully loaded and slack is eliminated. Pay attention to strap position during transfer.” On 08/13/25 at 02:06 PM, an interview with Director of Nursing (DON) was done. DON stated after the incident they called the vendor to find out what could have happened and were told “…the strap might have shifted during the lifting which caused the straps to snap out…” DON reported, after the incident, chest x-ray was done at the facility and results were negative. R2 was sent to the emergency room (ER) and hospitalized the next day, on 07/26/25, after complaining of pain to left side. At the ER, R2’s x-rays found fracture to left ribs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125013	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maunalani Nursing and Rehabilitation Center	5113 Maunalani Circle Honolulu, HI 96816

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R2’s ER physician notes documented, “Patient is at nursing home after prolong battle with pneumonia…He states he was being lifted in a .[mechanical lift] .yesterday when part of it malfunctioned and he landed on his left posterior ribs and hit his head. He has noted significant rib pain since and notes that he has mild shortness of breath and feels his ribs moving. He had an x-ray last night and was told everything was fine but he feels something is wrong. Pain is significant…” R2’s history and physical documented “Patient presents from nursing home complaining of left rib pain. Patient was being lifted in the Hoyer lift one of the straps was not connected properly and the patient fell 3 feet landing on mostly left side.” Review of R2’s ER x-ray results on 07/26/25, found “Acute appearing fractures of the lateral left sixth. Four, and second ribs. Worsening lower lung opacities. Small left apical pneumothorax.” Further review of R2’s physician notes dated 08/20/25, documented R2 was admitted to the hospital on [DATE] due to closed traumatic facture of ribs of left side with pneumothorax. R2’s pneumothorax worsened on 07/29/25 requiring pigtail chest tube placement from 07/29/25 to 08/10/25. Review of the facility’s policy and procedure “Hoyer Lift Safe Use Policy” dated 07/28/25, documented “A minimum of two trained staff members is required for all mechanical lift transfers.” On 08/13/25 at 03:15 PM, an interview with CNA Supervisor, CNA57 was done. CNA57 was not able to provide documentation that NA23 was trained to use the mechanical lift to meet the facility’s policy requiring a minimum of two trained staff. The facility uses a checklist that the CNA or NA orientee signs after a trainer goes over what is included in the checklist and CNA57 confirmed NA23 did not sign it. 2) R1 is an [AGE] year-old female admitted to the facility on [DATE] for short-term rehabilitation. Her admitting diagnoses include, but are not limited to, a history of stroke, gastrostomy (a surgical opening into the stomach for the introduction of nutrition and/or medication), and dysphagia (difficulty swallowing foods or liquids). On 08/11/25 at 11:47 AM, observations were made at the bedside of R1. R1 was lying in bed sleeping connected to oxygen via nasal cannula (indicating respiratory issues), with a suction machine at the bedside without any suction tubing, suction canister, or yankauer (rigid, curved, suction tip connected to suction tubing). On 08/11/25 at 11:51 AM, an interview was done with Registered Nurse (RN) 3. RN3 validated that due to R1’s dysphagia, she is to have nothing by mouth, however the suction machine is kept at the bedside “just in case it is needed.” RN3 agreed that the suction machine at the bedside was no good without the suction canister, suction tubing, and yankauer, stating, it should definitely be there. During a concurrent review of R1’s physician orders, the following order was revealed: Suction PRN [as needed] for oral secretions. When asked why it was important to have the suction machine set-up and ready to use at any time, RN3 answered “to prevent an accident.”