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	06/10/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews, documents and record review, the facility failed to respond to a family member's (FM) email grievance regarding Resident (R)1's stay at the facility. The facility reported no grievances during period requested (September 2025 to June 8,20-26). There was no follow-up documentation, resolution, or communication to the FM. This failure resulted in several of the FM's concerns remaining unaddressed and caused ongoing dissatisfaction. Findings include:1) On survey entry, requested the facility grievance log from September 2025 to current. On 06/08/26 at approximately 01:00 PM, interviewed the Administrator (ADM) and the Director of Nursing (DON) about the facility process for grievances. At that time, interviewed the ADM, who said they did not have any grievances during the period the log was requested.2) On 06/09/25 at 09:38 AM during a second interview with the ADM, she stated she found an email the previous night in her spam file with a grievance from R1's FM that was sent to her and copied to the Ombudsman and the Office of Healthcare Assurance. She said she could not explain why the email went to spam, but she had been unaware of the email until last night. The concerns identified included 1) Physical and Occupational (PT/OT) therapy 2) toileting 3) Certified Nurse Assistants restricted in mobility assistance, 4) Physician visits, and 5) inaccurate past medical history of a knee replacement documented in the medical record. The ADM acknowledged the error and stated the grievance should have been acknowledged, thoroughly investigated with results summarized and a response to the complainant in a timely manner. The ADM said she was aware the FM met with the Director toward the end of R1's stay, and discussed concerns about PT and OT, so she thought the issue had been resolved to FM's satisfaction.3) Reviewed R1's Occupational Therapy notes, which included the following: - 10/01/25: .FM expresses displeasure with therapy and states she will be appealing DC. FM expressed displeasure with amount of therapy pt received and wanted more. FM wanted nurses to walk more with PT. - 10/13/25: .FM, aired her grievances to OT and MSW. FM is unhappy with the level of care . has received . - 10/14/25: .OT fielded multiple complaints from FM about the amount of time it took for pt (R1) to get to this level. FM also complained about certain therapist and had a hard time recalling what OT had been done. 4) Reviewed the facility policy titled Grievance/Complaint Policy last revised June 18,2025. The policy included 2. The Grievance/Complaint form will be completed and signed by the resident, or the person recording the grievance or concern on behalf of the resident. The completed form must be given to the Unit Nurse who will date and time the form and immediately send it to the Licensed Social Worker or Director of Nursing. 3. Upon receipt of the written Grievance Form, the LSW or DON will conduct an investigation of the grievance/complaint by interviewing all witnesses, . Findings will be documented and presented to the Administrator. 4. The Administrator will review the findings with the person(s) investigating .and ensure all appropriate actions are being taken. 5. A follow-up call will be made to the person who voiced concern or filed the written grievance/complaint. The Administrator will communicate actions taken and check for early satisfaction within 3 business days from the date of the Grievance/Complaint was received

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

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and review of medical records, documents and policies, three Resident ((R)1, R2 and R3) of a sample size of three, had incomplete medical records. Physician visits and/or discharge summary and initial admission orders lacked timely signature by the attending physician as required by regulatory standards. In addition. one initial History and Physical (R)1 was not documented in the medical record (EMR). These deficiencies do not meet the requirements for timely and authenticated physician documentation to support continuity of care and compliance with federal regulations. Findings include:1) R1 was admitted to the facility on [DATE] for subacute rehabilitation and skilled nursing management following hospitalization for sepsis secondary to a urinary tract infection. Reviewed R1's medical records on 06/08/26, which revealed the following: - Initial admission orders were entered into the EMR by the nursing staff on the date of admission, 08/05/25. There was no evidence in the medical record that these orders had been signed by Physician (MD)1. Request made for documentation the orders were signed. - The medical record did not have an initial comprehensive history and physical (H&P). The Director of Nursing (DON) confirmed it was not in the medical record and said she would investigate. On 06/09/2025, the DON provided the initial H&P. Review of the H&P revealed it was electronically signed by MD1 and posted in the EMR on 06/09/2026. In addition, the date of Transition to SNF in the H&P was documented to be 08/04/25, which was incorrect. The correct date was 08/05/25. - The discharge summary with encounter date 10/17/25 was not signed and dated timely. It was in the medical record but not electronically signed by MD1 until 11/19/26. On 06/10/26 at approximately 12:30 PM, the Administrator (ADM) confirmed R1's admission orders had not been signed by MD1. She said the process has been the Nurse will contact the physician and review the current medication list on the hospital discharge summary. The physician approves to continue those medications, adds or adjusts as appropriate for the initial admission orders.On 06/10/26 at 01:15 PM interviewed MD1 in the conference room. He said the nursing staff will inform him when there is a new admission, and then he reviews all of the Resident's records available that includes the discharge summary, completes initial review of orders, and schedules the initial visit. He went on to say the nursing staff put the admission orders in the EMR, and he later signs them manually. MD1 said he was not aware there was an electronic signature feature available until recently. MD1 confirmed he did R1's initial H&P, documented it timely, but had not signed it until it was brought to his attention on 06/09/26. The H&P was posted to the EMR after it was signed. Informed MD1 the admission date documented in R1's H&P was incorrect and that he was admitted on [DATE] rather than 08/04/26. He acknowledged the process to sign admission orders needed to be corrected and agreed that all notes needed to be signed and posted timely. MD1 did not recall any discussion with R1's family member (FM) regarding a concern and revision request to R1's H&P that included a knee replacement the FM said he did not have.2) R2 was transferred from acute care and admitted to the facility on [DATE]. On 06/10/26, reviewed R2's medical records, which revealed the following: - A two-page templated document titled Physician's Order: Admission, dated 04/14/26. The document identified MD1 as the Provider. The orders included medication orders, oxygen, code status, therapy and the statement certifying the need for SNF (skilled nursing facility) level of care level. The Physician Order: Admission had two places for signatures, the Nurse Signature and Physician Signature. The orders were signed and dated by the nurse but was not signed by MD1. - Physician Visit Note encounter date 05/04/26: The visit note was not signed in a timely manner as it was electronically signed by MD1 on 05/21/26. 3) R3 was transferred from acute care and admitted to the facility on [DATE]. Review of R3's medical records revealed the following:- The Physician Order: Admission document identified MD1 as the Provider. The initial orders dated 04/01/26 had a Nurse Signature, but was not signed by MD1.- Physician Visit Note encounter date 04/22/26: The visit note was not signed in a timely manner as it was electronically signed by MD1 on 05/11/26. 4) Reviewed (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility policy titled Physician Services, revised July 27, 2025, which included 4. Physician orders and progress notes shall be maintained in accordance with State and Federal regulations and facility policy.