STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125024	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nuuanu Hale	2900 Pali Highway Honolulu, HI 96817

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a safe discharge for one Resident (R)2 of a sample size of three. Specifically, prior to an inpatient hospitalization, R2 was moderately independent with some assistance, but his functional level changed. At discharge, he required maximum assistance for most activities of daily living. There was lack of evidence that R2's discharge home met his identified needs of 24/7 supervision. Caregiver availability, capacity and capability were not determined. As a result of this deficiency, R2 was at high risk of readmission and harm. This deficient practice has the potential to affect any resident discharged home. Findings include: 1) On 02/07/2025 the Office of Healthcare Assurance (OHCA) received a report from an external agency regarding concern of R2, self neglect and possible inappropriate discharge. The report included R2 lived with his girlfriend, but that she was disabled and not able to care for him. It also documented he does not have any other support system and .girlfriend is only able to assist with grocery shopping. 2) R2 was a [AGE] year-old admitted to the facility on [DATE] for short term physical and occupational therapy to improve functional status due to weakness and immobility after being hospitalized for sepsis. His medical history included poorly controlled Diabetes, muscle weakness, thoracic and cervical spinal stenosis, stroke with left sided weakness. and incontinence of bowel and bladder. R2 is capable of making his own decisions. Prior to admission he lived at home with his significant other, who assisted him. He was discharged home on [DATE], with a referral to Home Health. 3) Reviewed R2's hospital Rehab Consult Notes dated 12/27/2024, which included the following: - Lives with: .lady friend. - Assistance at discharge: Family, Home Alone During the Day. - Home equipment: shower chair. wheelchair, transport, walker, rolling. - Living Environment Comments: Pt reported that when his lady friend stays over she helps but when she does not he performs tasks on his own. (continued on next page)

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Toileting prior to admit 12/24/2024 level of function: pt. (patient/R2) reported that he takes his transport w/c (wheelchair) to the bathroom door then uses his RW (rolling walker) to get to the toilet. - Prior fall history: Pt has fallen a lot and reports that when he falls on his face he can not even breathe or turn his head to help him. Pt reports he can lay there half an hour before being found by significant other. Reviewed R2's facility Occupational Therapy (OT) Discharge Summary, for services ending on 01/26/2025. The summary included the following: Eating: Sup (supervision)/SBA (standby assist)- Cueing, coaxing, standby for safety; Hygiene: Oral hygiene = Mod A (Moderate Assist, 26-50% care giver support); Toileting hygiene = Dependent (100% assist), or two or more helpers; Transfers: Toilet transfer = Total A (79-99% assist), substantial Maximal Assist; Bathing: Shower/bathe self = Dependent; Dressing: Upper body dressing = Mod A; Lower body dressing = Total A; Putting on/taking off footwear: Total A; Self-Care Performance Skills: Self Care Function Score (score 0-12; 12 being highest function) = 5; Discharge Recommendations: Air mattress, 24 hour care, Home exercise program, Home health services and in-home aide. 4) Reviewed R2's Physical Therapy (PT) Discharge Summary for services ended on 01/27/2025. The summary included: Bed mobility: PLOF (Prior level of functioning): MODI; discharge: Mod-Max assist, MOD to roll to sides, able to pull self with .but requires MAX A (maximal assist-caregiver provides 51-75% of effort) to complete supine to sitting and back. Transfers (bed to chair/chair to bed, sit to stand, toilet transfers): PLOF: MOD I; discharge: MAX A/TA (Maximum Assist/Total Assist-caregiver does 100%). Standing Balance: PLOF: Fair; (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge: Poor. Ambulate with FWW (front wheel walker) to 10 ft: PLOF: MOD I-20 ft.; discharge: Attempted, but not able to demonstrate any steps. Mobility Score: Functional Mobility Score (ranges from 0-12; 12 being highest function) = 2. Discharge Location = Patient discharged to home w/support/(A) from others. Assistance/Support to be provided = Community Assistance. AM assistance/caregiver available, PM assistance/caregiver available. D/C Recommendations: Assistive device for safe functional mobility, ., Elevated toilet seat/3 in 1 commode, Environmental modifications, Functional Maintenance Program, Home health services, Shower chair back, Grab bars and Reacher. 5) Reviewed R2's discharge MDS (Minimal Data Set) dated 01/28/2025 revealed Section GG-Functional Abilities documented the following: Eating: 5 (Setup or clean-up assistance) Oral Hygiene: 5 (Set up or clean-up assistance) Toileting hygiene: 1 (Dependent) Shower/bathe self: 2 (Substantial/maximal assistance) Upper body dressing: 3 (Partial/moderate assistance) Lower body dressing: 2 (Substantial/maximal assist) Putting on/taking off footwear: 1 (Dependent) Person hygiene: 2 (Substantial/maximal assist) (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6) On 03/27/2025 at 01:39 PM, interviewed the facility's Assistant Director of Rehab (PTA), in the conference room. The PTA said the Physical Therapist comes to the facility and does the admission evaluations and develops the plan, and then the PTA provides the therapy. When asked PTA about R2, he said Across the board he was max assist. He went on to say, R2's baseline was that he needed some assistance at home, and his girlfriend helped him, but his condition and needs changed. The PTA said at discharge, R2 could not ambulate and could not transfer self from bed to wheelchair. When inquired if his department does caregiver training, he said in this case, he thought there had been attempts to get the girlfriend in, to provide her training, but she never came. At that time reviewed the discharge evaluation note, and PTA confirmed he wrote the content, and the Therapist electronically signed it offsite. He went on to say they recommended home care therapy and Social Services would make the arrangements. The PTA recalled they discussed options for R2 post discharge at a care planning meeting, but that He was adamant about going home. On 03/27/2025 at 02:00 PM, interviewed Social Services (SS) in the conference room. He said his supervisor was assigned R2, but she was unavailable. SS said he did have some knowledge of the resident and was sure R2 had been offered other options such as care home, but He (R2) had one adamant request, which was to go home, and was not interested in any other option. At that time, reviewed all discharge planning notes and SS confirmed there was no documentation that other options other than home were discussed to ensure his safety. He said a referral was made for PT/OT home health services. On 03/28/2025 at 11:16 AM, interviewed the Physical Therapist (PT) in the conference room. PT did R2's admission evaluation and electronically signed his discharge summary. He confirmed his involvement with R2's care. At that time, PT reviewed R2's therapy documentation, and noted there had been a decline in R2's functional level while he had been at the facility. He confirmed at the time of the discharge evaluation on 01/27/2025 R2 needed maximum assistance. On 03/28/20025 at 12:40 PM, PT returned to he conference room after he reviewed P2's records again, and said he noted in the Occupational Therapy notes, there was a recommendation for 24 hour supervision. 7) On 03/28/2025 at 10:34 AM, conducted a phone interview with the Home Health Agency (HHA), who confirmed a referral was uploaded into their system on 01/28/2025, for PT, OT and Aide services. The home evaluation was conducted on 01/31/2025 and due to unsafe home environment, R2 was not admitted for services. The HHA notified R2's insurance coordinator to assist with further care coordination. 8) Reviewed the facility policy titled Discharge/Transfer, which included The post-discharge plan will be developed by the interdisciplinary team with the assistance of the resident and resident representative. As [sic] a minimum, the post-discharge plan will include a current assessment of resident's ADL (Activity of Daily Living) functioning .social services, and physical therapy as appropriate. In addition, the post-discharge care plan will address follow up with PCP as well as provisions for medical equipment, housekeeping needs, meals .A telephone follow-up call will be performed one week after discharge by the Social Worker or designee to inquire as to status and adjustment of the resident, as appropriate. There was no evidence a follow-up phone call had been made to R2.