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	02/27/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure staff reported an injury of unknown source that resulted in serious bodily injury no later than two hours after discovery to the facility Administrator for one of one resident (Resident (R) 70) reviewed for abuse. Specifically, staff were aware that R70 had a large bruise on left hip and thigh, first observed on [DATE], but the injury was not reported to the Administrator and State Agency until [DATE]. Findings Include:Cross reference to F726, Competent Nursing Staff. The facility failed to ensure licensed nursing staff demonstrated the appropriate competencies and skill set to provide a thorough and accurate skin assessment of R70 after observing a large bruise on the resident's left hip and thigh. R70 was admitted to the facility on [DATE] and deceased with hospice services on [DATE]. R70's diagnoses included, but not limited to, hereditary ataxias/[NAME]-[NAME] disease, dementia with behavioral disturbance, lumbar spinal stenosis without neurogenic claudication, lumbar disc degeneration with discogenic back pain, hyperlipidemia, hypertension, venous insufficiency, anxiety disorder, major depressive disorder with psychotic symptoms, bilateral keratoconus muscular dystrophy, agoraphobia with panic disorder, and sciatica.Review of the initial facility reported incident (Intake #2578903), received on [DATE], documented that staff observed a bruise on R70's left hip and left thigh. A completed report submitted on [DATE] documented that a Certified Nurse Aide (CNA) working the night shift observed the bruise on [DATE] but forgot to report it to the Charge Nurse and instead relayed the information only to the incoming day shift CNA on [DATE]. The day shift CNA informed the Registered Nurse (RN) on duty. Upon assessment, RN noted that bruise appeared purple in color with location at left thigh (posterior). Resident did not remember how it happened and denied any pain or discomfort. When RN assessed resident, she assumed bruise was already reported to a licensed staff and did not need to make an initial entry. The Director of Nursing (DON), Administrator, physician, resident, representative, and State Agency were not notified until [DATE]. Review of RN10's written response in the facility's investigation, dated [DATE], stated I am unsure of how the bruise may have occurred. During the transfer from wheelchair to shower chair. [Restorative Nurse Aide (RNA)] .relayed to me that.[CNA30] .had alerted her about the bruise. This was the first time it was reported to me. [RNA] .relayed the bruise was not from today but another day.Given that. [CNA30] .was aware I assumed. [CNA30] .reported the bruise to the assigned license nurse on her shift.On [DATE] at 08:20 AM, a telephone interview was conducted with CNA30. CNA30 could not recall the exact date she worked when she observed the bruise. Review of the facility's July CNA schedule showed CNA30 worked from 11:00 PM to 7:00 AM on [DATE] into [DATE]. CNA30 reported that around 12:00 AM on [DATE], she observed a big, dark bruise on R70's thigh. CNA30 confirmed she did not notify the night shift nurse due to being busy and forgetting, but she told the day shift CNA during shift change. She could not recall which CNA she endorsed the bruise to. CNA30 acknowledged she made a mistake by not reporting to the nurse on duty.On [DATE] at 08:37 AM, (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview was conducted with RNA. RNA reported she first became aware of the bruise on [DATE] while assisting CNA8 with R70's care. The RNA described the bruise as large and located in the lower hip area. The RNA confirmed with CNA8 that the on?duty nurse, RN10, had been informed. The next day, on [DATE], the RNA observed another large bruise on R70's thigh and reported it to Licensed Practical Nurse (LPN) 3.On [DATE] at 08:45 AM, a telephone interview was conducted with CNA8. CNA8 stated she first saw and heard about the bruise on a Thursday, possibly [DATE], while assisting R70 with a shower. CNA8 reported she informed the RNA and RN10, who were assisting with care.On [DATE] at 11:29 AM, an interview was conducted with Administrator. Administrator acknowledged that staff did not report the bruise timely to ensure she and the State Agency were notified within required timeframes.Review of the facility's abuse policy and procedure, revised on [DATE], documented An investigation is immediately conducted when there are allegations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property and shall be immediately report.Allegations that involve abuse or result in serious bodily injury shall be reported immediately, but not later than 2 hours after the allegation is made.The Administrator or designee shall be notified immediately, who will immediately initiate the report. to state agencies.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and interviews, the facility failed to ensure licensed nursing staff demonstrated the appropriate competencies and skill set to perform a timely, thorough, and accurate skin assessment for one of one resident (Resident (R) 70) reviewed for abuse. Specifically, staff were aware that R70 had a large bruise on left hip and thigh, first observed on 07/30/25, but an initial assessment was not conducted, and subsequent skin assessments did not document the presence, location, size, characteristics and/or progression of the bruise. This deficient practice places R70 at risk for unrecognized injury progression and delays in appropriate monitoring, intervention, investigation, and implementation of protective measures to safeguard the resident's health and safety.Findings Include: Cross Reference to F609, Reporting of Alleged Violation. The facility failed to ensure staff reported an injury of unknown source that resulted in serious bodily injury, large bruise to left hip and thigh, no later than two hours after discovery to the facility Administrator. The injury was first observed on 07/30/25 but was not reported until 08/01/25. Review of the initial facility reported incident (Intake #2578903), received on 08/01/25, documented that staff observed a bruise on R70's left hip and left thigh. A completed report submitted on 08/07/25 documented that a Certified Nurse Aide (CNA) working the night shift observed the bruise on 07/30/25 but forgot to report it to the Charge Nurse and instead relayed the information only to the incoming day shift CNA on 07/31/25. The day shift CNA informed the Registered Nurse (RN) on duty. Upon assessment, RN noted that bruise appeared purple in color with location at left thigh (posterior). Resident did not remember how it happened and denied any pain or discomfort. When RN assessed resident, she assumed bruise was already reported to a licensed staff and did not need to make an initial entry. On 08/01/25 a day shift Licensed Practical Nurse (LPN) observed the bruise on left hip and thigh and notified the physician. An X-ray was ordered and it revealed AP [Anteroposterior] and lateral views obtained. There is no acute fracture or dislocation. Joint spaces are aligned and maintained. There are no bony lesions. Mineralization is normal. Soft tissue swelling is noted. Impression: Soft tissue swelling without acute osseous abnormality.Review of RN10's written response in the facility's investigation, dated 08/01/25, stated I am unsure of how the bruise may have occurred. During the transfer from wheelchair to shower chair. [Restorative Nurse Aide (RNA)] .relayed to me that.[CNA30] .had alerted her about the bruise. This was the first time it was reported to me. [RNA] .relayed the bruise was not from today but another day.Given that. [CNA30] .was aware I assumed. [CNA30] .reported the bruise to the assigned license nurse on her shift.On 02/26/26 at 09:25 AM, an interview was conducted with LPN3. LPN3 stated skin assessments are done weekly, routinely, and when a new skin issue is observed. LPN3 confirmed she observed a large purplish bruise from R70's lower hip to the thigh on 08/01/25 and did not measure the bruise. LPN3 confirmed she found no assessment or event note prior to 08/01/25, identifying the bruise, prompting her to create an event and notify the Director of Nursing (DON). When asked if weekly skin assessments should include the unresolved bruise, LPN3 stated the bruise should be documented in the skin assessment.Review of the weekly skin assessments on 07/31/25, 08/07/25, 08/14/25, 08/21/25, and 08/28/25 by RN10 revealed no documentation of the bruise on the left hip and thigh. The skin assessment was documented the same including skin description, that there were no new onset skin impairments, describing only Dry scattered scabs to bilateral shins and on Medihoney gel- areas are dry and healing except for which CNA assisted with the assessment.Review of the event report initiated on 08/01/25 by LPN3 documented the following in nursing notes:08/01/25: Noticed bruise on the left hip and left thigh.8/02/25: Still with visible bruise on left hip and left thigh.08/03/25: Resident with fading bruise on the left hip and (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left thigh. and Left hip/thigh still bruised.08/04/25: With fading bruise to L [left] him and thigh, yellow and purple in color.08/07/25: Resident with fading bruise on the left hip and left thigh.08/09/25: Left hip and left thigh bruise is fading. and Left hip and left thigh bruised is fading.08/10/25: Left hip and left thigh bruise is fading.08/11/25: With fading bruise to L hip and L thigh. Bruise yellow in color.08/14/25: Bruise to L hip and L thigh fading. Bruise is currently yellow in color.08/15/25: Bruise to L hip and L thigh fading. Bruise is currently yellow in color.These notes did not include a complete skin assessment or documentation of the bruise's progression, including color, size, and shape, the initial appearance, or date of resolution. On 02/26/26 at 11:59 AM, interviews were conducted with Infection Preventionist (IP) and Administrator. Both confirmed RN10 did complete proper weekly skin assessments, which should have included the bruise. The IP stated that if a new skin issue is identified, staff should immediately perform a full skin assessment and initiate a RMC Injury/Integumentary Alteration event, requiring documentation of description and type of injury, location and size, pain, activity during discovery, who was notified, and nursing notes/monitoring. The IP and Administrator confirmed RN10 should not have assumed an assessment had been completed and should have reviewed R70's chart to ensure the injury was assessed and reported. They also confirmed the event report initiated by LPN3 was not the correct form and did not include a complete assessment of the bruise.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program to ensure a safe, sanitary, and comfortable environment and to prevent the development and transmission of communicable disease and infections. Specifically, the facility failed to ensure the following: Keep Urinary catheter tubing off the floor and tubing with visible sediment was cleaned or changed as required for of two of two residents (Resident (R) 8 and R53) sampled for urinary catheter care. Use Personal Protective Equipment (PPE) while providing catheter care to Resident (R) 53 who is on Enhanced Barrier Precautions (EBP).To implement the water management plan for legionella prevention and control.To dispose of trash promptly, instead piled trash outside of the trash bin. Findings Include: 1) On 02/24/26 at 9:28 AM, during an interview with R8, the surveyor observed the resident's urinary catheter bag on the floor inside a gray bin next to the bed. The catheter tubing was observed outside of the gray bin and in contact with the floor. The tubing contained visible discoloration and white sediment inside the tube. On 02/26/26 at 9:44 AM, R8 reported experiencing itchiness outside of her vagina and stated that her urinary catheter was leaking. On 02/26/26 at 9:48 AM, during an interview with Registered Nurse (RN) 22, asked whether she was aware that R8's catheter tubing contained sediment. RN22 stated she was aware and planned to contact R8's physician to request more frequent catheter changes, as the catheter was currently changed once a month. RN22 reported the tubing could be cleaned by irrigating it with saline. When asked if catheter tubing should be on the floor, RN22 stated it should not be on the floor for infection control reasons. On 02/26/26 at 3:21 PM, during an interview with the Infection Preventionist (IP), the surveyor asked how often nursing staff are to irrigate catheter tubing. The IP stated staff should irrigate the tubing when they notice the unit is not draining due to sediment. The surveyor showed the IP a photograph taken on 02/24/26 of the resident's catheter tubing on the floor and the condition of the tubing. The IP confirmed the tubing should have been changed and that the catheter tubing should not be on the floor due to the risk of infection. 2) Electronic Health Record (EHR) reviewed on 02/25/26. R53 is a [AGE] year-old male admitted to the facility on [DATE]. Diagnosis includes Stroke, with impairments of his upper and lower extremities; Benign prostatic hyperplasia (Enlarged prostate) with lower urinary tract symptoms and requires an indwelling urinary catheter. He is dependent on staff for his personal care. R53 is on enhanced barrier precautions which indicates that staff put on personal protective Equipment (PPE) gown and gloves while providing any personal care or physical contact with the resident. Orders dated 06/27/25 reviewed. Catheter care every shift and PRN (as needed). Observation and interview with Registered Nurse (RN) 25 on 02/25/26 at 09:35 AM in R53's room at the bedside. Observed R53's catheter tubing laying directly on the floor. The bed was placed in the lowest position. When sharing the observation with RN25, she said it shouldn't be on the floor, and they need to place the bed in a low position but not too low so the catheter doesn't touch the floor. RN25 repositioned the bed and placed the tubing in the tray. 3) Observation in R53's room with Certified Nurse Aide (CNA) 15 on 02/26/26 at 10:01 AM. Noted a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	pungent odor like urine at R53's bedside near the urinary catheter bag. CNA15 put on gloves and completed the catheter care by emptying the catheter bag and cleaning the lower area of the catheter tube with an alcohol pad. After draining the catheter bag, she cleaned the area of the floor where the catheter bag is stored with wipes from the purple top. CNA15 was not wearing a PPE gown. The Infection Preventionist (IP) was interviewed on 02/26/26 at 10:42 AM in the conference room. Asked her if R53 is on enhanced barrier precautions. The IP said yes, because he has a foley catheter. Asked her if the staff should wear the PPE when doing the catheter care such as emptying the collection bag, she said yes, they should in case it splashes. Shared the observation made with CNA15 and that she was not wearing her PPE when she provided the catheter care. CNA15 interviewed on 02/26/26 at 10:56 AM outside of R53's room. Asked if she is supposed to wear PPE when she is providing care for the catheter. CNA15 answered yes. Asked where the PPE is located since it was not visible outside the room. CNA15 said it is over there and pointed down the hall to the PPE shelf on the wall. The IP was interviewed on 02/26/26 at 3:17 PM in the surveyor conference room. When asked if the staff are familiar with the PPE being located on the wall as opposed to having it stored outside of the room where it is readily available, she said they should, it was moved there two weeks ago and they were provided training. EBP policy revised: 01/03/25 reviewed. Definitions: EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. 13. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room.14. High-contact resident care activities include g. Device care or use: urinary catheters, . 4) Water management plan program implemented date 12/25 reviewed on 02/26/26. 1. The water management team has been established in the guidelines to include the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing. 4. Water system description. The facility maintains: Central hot water system with recirculation. Cold water distribution system: hot water distribution system; ice machines located in designated areas. Shower and faucet fixtures in resident rooms. Hot water setpoints: Storage tanks: Greater than or equal to (>)140 degrees Fahrenheit. Distribution: > 124 degrees Fahrenheit .Monitoring Procedures include monthly hot water temperature by maintenance. Asked the Maintenance Director (MD) on 02/26/26 at 2:30 PM the location of the 140-degree storage tank. The MD said there are no storage/ water heater tanks with water with temperatures greater than 140 .8. Verification & Validation. Review monitoring logs monthly Review infection surveillance data and water testing results .9. The facility maintains: Temperature logs. Flushing logs. Cleaning scheduled Corrective action reports. Annual program review documentation. Approved on 02/06/26 by the Administrator. One month of temperatures were found for review in the binder for the resident rooms and water heaters (between 105 and 115 not to exceed 120) and does not pertain to the legionella prevention temperature guidelines from the Center for Disease Control and Prevention (CDC). There was no measure in place to disinfect potential contamination of water with the legionella pathogen. The IP was interviewed on 02/27/26 at 1:32 PM in her office. The IP stated that she just came into (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the position at the facility IP this month and the previous IP left last month. Asked who are the members of the water management team and has it been implemented. The IP responded that she was not familiar with the water management plan since she just started the position this month and the collaboration between the IP and maintenance director is non-existent. When asked if the risk assessment was completed and what type of control measures are in place. The IP said that no control measures are in place. The weekly monitoring of the flushing of the shower heads, faucets and the Monthly temperature monitoring is also not being done. 5) The Department of Health Office of HealthCare Assurance (OHCA) received an anonymous complaint regarding trash overload at the facility on 08/26/25. On 02/25/26 at 11:30 AM, observed three bags of thrash outside the facility next to the trash bin and multiple bags of thrash on the stairwell landing of the staircase outside of the facility leading to the second floor, blocking access to go up and down the staircase. On 02/25/26 at 01:30 PM, interview with Housekeeping Staff (HS) 1 responsible for the emptying trash on the second floor noted that she puts the collected trash bags in the bin at least every hour to prevent the overflow on the outside staircase, but sometimes needs to wait for the Maintenance Worker (MW) as he is the only one with the keys to open the bin. Interview with HS2 who is responsible for the thrash on the first floor noted that she will take the trash bags and leave it out by the bin at least twice a day, in the morning and afternoon. HS2 stated that the trash bags are too heavy for her to place in the bin so she would call the MW to place the trash bags in the bin. HS2 noted that she notified MW that there was trash to be placed in the bin about an hour ago, but not sure why it was still not placed in the bin. On 02/25/26 at 02:00 PM, interview with MW completed. When asked why the trash was still outside of the bin, MW noted that the aides told him to hold off putting it in the bin but was not sure why. On 02/26/26 at 09:30 AM, interview with Administrator confirmed the overflow of trash started back in May of 2025. The Administrator noted that they were using a waste management company who could not meet the scheduled pick-up frequency of three times a week, which caused the overflow. The Administrator stated that they have implemented changes to include switching over to a new waste management agency on 09/25/25 and acknowledged the importance of keeping the trash under control for infection control purposes. On 02/27/26 at 08:15 AM, interview with Maintenance Director (MD) confirmed that the housekeepers should be putting the trash in the bin more frequently but did not know why the first floor HS cannot put the trash directly in the bin and they cannot rely on or wait for the MW as he gets busy. MD acknowledged that the trash pile up can lead to unsanitary conditions that can affect the facility and neighborhood.