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 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). (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
	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a written notification to the resident representative of resident's transfer for three out of three residents (Resident (R) 66, R1, and R6) sampled for hospitalizations and failed to send a notification of the discharge to the long term care ombudsman's office for one of one resident (R68) sampled for discharges. The facility also failed to have the Ombudsman address and appeals right information noted on their notification form. As a result of this deficient practice, residents who are discharged /transferred from the facility are affected.Findings Include: 1) On 02/25/2026 at 01:00 PM, record review of R66's Electronic Health Record (EHR) noted that R66 was sent to the emergency room (ER) for critically low platelets on 11/28/25. R66 received blood transfusion and was admitted for subdural hematoma and remains hospitalized . On 02/25/26 at 01:00 PM, requested for the written discharge notification to family representative and Ombudsman from the Administrator. On 02/26/26 at 11:35 AM, no discharge/transfer notification received for R66. Concurrent interview with Social Worker Aide (SSA) 1 confirmed that no written notification to family representative and Ombudsman was completed. 2) 02/25/2026 at11:11 AM, interview with R1 noted that he went to the hospital couple of months ago for abdominal pain. On 02/25/2026 at 01:00 PM, record review of R1's EHR noted that R1 was admitted to the hospital on [DATE] for small bowel obstruction. On 02/25/26 at 01:00 PM, requested for the written discharge notification to R1's family representative and Ombudsman with the Administrator. On 02/26/26 at 11:35 AM, no discharge/transfer notification provided for R1. Concurrent interview with SSA1 confirmed that no written notification to family representative and Ombudsman was completed. 3) EHR reviewed on 02/26/2026. R68 was admitted to the facility from an acute care hospital to Hospice care on 09/17/25. Diagnosis included alcoholic cirrhosis of the liver. R68 was discharged home on [DATE] on hospice care. The Ombudsman discharge notices binder was reviewed on 02/27/2026 at 07:17 AM, R68's notification was not found. SSA2 was interviewed on 02/27/2026 at 10:08 AM. Asked if there was a notice sent to the Ombudsman when R68 was discharged on 12/12/25. The SSA2 confirmed there was no discharge notification sent to the Ombudsman and added that he was the only SSA who was covering at the facility during the time the resident was discharged . Typically, the SSA2 sends a fax notice to the Ombudsman. (continued on next page)

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) During record review of R6's Electronic Health Record (EHR) on 02/25/26 found R6 was discharged and returned to the facility in December 2025 and February 2026. R6 was transferred to the emergency room (ER) for further evaluation on 12/14/25 when he had a change of level of consciousness (LOC). R6 was admitted to the hospital for Acute Hypoxemic Respiratory Failure / on oxygen (O2). R6 was readmitted to the facility on [DATE] and his Principal diagnosis was Methicillin-resistant Staphylococcus aureus (MRSA) septicemia due to Central Venous Catheter (CVC) infection. On 02/12/26 R6 was sent to the ER when he became unresponsive. R6 was admitted to the hospital on [DATE] for sepsis. R6 returned to the facility on [DATE]. Review of R6's EHR revealed there was no documentation in writing that the resident or his representative was given notification of these transfers/discharges and there was no documentation the Ombudsman was notified of the transfers/discharges. On 02/27/26 at 10:02 AM interviewed Social Services Aide (SSA)2 in the conference room. Inquired of SSA2 if he had given written notification of transfer to R6 or his representative and he stated he did not. Inquired if the Ombudsman had been notified of R6's discharge to the hospital in December 2025 and he stated he had not notified the Ombudsman, that the facility was catching up with this. SSA2 stated the Ombudsman requested to be notified monthly and the February 2026 discharges will be sent to the Ombudsman in March.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of the facility's policy, the facility failed to ensure that food items stored in the walk-in freezer and refrigerators were labeled properly and old food discarded. This deficient practice places residents in the facility at risk of foodborne illness.On 02/24/26 at 08:20 AM, during the initial walkthrough of the kitchen with Dietary Lead (DL), observed frozen vegetables and meats without any labels in the walk-in freezer. The refrigerator also had vegetables and soup base items not labeled with receive and discard date. Observed a minced onion container in with a Best used by date of 01/26/26 still in the refrigerator. Concurrent interview with DL confirmed that in the freezer they have not been labeling the food items with received/discard date and for the refrigerator they only label food with the discard date. At 10:00 AM, interview with the Dietary Manager (DM) noted that they do not label food items in the freezer as they order items based on usage. DM noted that frozen foods are used, consumed, and ordered on a weekly basis. DM provided invoices for several food items that were ordered through the facility's food vendor on the following dates:Invoice # 3447933 was ordered on12/17/25, but it did not indicate a received by and date received information.Invoice # 3470342 was ordered on 02/11/26, but it did not indicate a received by and date received information.Invoice # 3473185 was ordered on 02/18/26, but it did not indicate a received by and date received information.Invoice #34735132 was ordered on 2/19/25, but it did not indicate a received by and date received information.Only invoice #02481435, dated 02/18/26 had a received by signature and a received date of 02/18/26. When DM was asked what system did he have in place to ensure that food are discarded appropriately when there are no receive/discard date labels on them, DM noted that he uses the trust system, stating that his employees have over 30 years of experience and would look at the food for their appearance, smell, and taste and if appeared spoiled would discard them. DM also provided a Custom Culinary Julain Code explanation for the beef base containers that were not labeled but had difficulty noting what the discard date would be. Requested from DM their Food Storage and Labeling policy but stated they did not have one. On 02/25/26 at 09:30 AM, interview with Administrator confirmed that they should have a Food Storage Policy and acknowledged there should be a system in place for food labeling and discarding of food and not just based on trust.On 02/27/26 at 09:30 AM, walkthrough of the freezer with the Administrator confirmed that there were no labels for food items stored in the freezer. Administrator stated that she saw labels on the items two days ago, but she was not sure why they do not have them today. Administrator acknowledged that labelling of food items is important to prevent foodborne illnesses.On 02/27/26 at 09:00 AM, review of the facility's Labelling Food policy, dated 10/2017, it notes in the Purpose section, all potentially hazardous food items shall be labelled to assure safe consumption and prevention of food borne illness. In the Protocol section, it notes: 1. All perishable food items will be labelled by dining services staff using two dates which indicate the date the product was opened initially and secondly indicating that date by which the item must be discarded, i.e: 7/1/15-7/4/15. 2. Food items not easily and/or visually identifiable and not in the original carton/packaging, labelling may indicate name of item, date initially opened and date by which item must be discarded, i.e: pureed chicken, 7/1/15-7/4/15.All non-perishable foods will be stored in the kitchen storage area and labelled with the date of receipt/delivery of items .

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, staff interviews and review of the dishwasher temperature logs, the facility failed to maintain the dishwasher temperature gauge was in safe operating condition. This deficient practice puts residents at risk for foodborne illnesses.Findings Include:On 02/24/25 at 08:30 AM, initial walkthrough of the kitchen with Dietary Lead (DL), observed dishwasher machine temperature daily log at 125 for the entire month of January until 02/24/26. Facility has a low temperature dishwasher where the recommended wash temperature should be at a minimum of 120 . Requested for Dietary Aide (DA) to complete a wash cycle. Observed throughout the wash and rinse cycle, the dishwasher temperature gauge did not move and stayed at 100 throughout the entire process. Concurrent interview with DA acknowledged that she has not been physically checking the temperature gauge daily and just noting 125 degrees on the log. Concurrent interview with DL noted they did not know the gauge was broken and will inform the Maintenance Director (MD) to fix it. On 02/24/25 at 10:00 AM, a follow-up observation to the kitchen noted the dishwasher temperature gauge showing 120 . Per DL, MD came to fix it. Premium (vendor the facility is contracted with to do kitchen equipment repairs) Representative (PR) was called to get a better understanding of the dishwasher functions and when temperature settings should be checked.At 11:00 AM, PR assessed the machine and ran the dishwasher for one cycle and noted that there was nothing wrong with the temperature gauge. The temperature gauge showed 130 .On 02/27/26 at 08:15 AM, interview with MD stated that he did not fix the dishwasher temperature gauge as it is not an equipment that he is responsible for repairing. MD noted that it is the Dietary Manager's (DM) responsibility to keep track of and call the vendor to fix it. MD also stated that he has told the dietary staff to check the dishwasher temperature with a thermometer until the gauge is replaced or fixed. MD stated he was not sure how long the gauge was broken.At 11:30 AM, observed PR showing Administrator and DA that the dishwasher gauge was now working properly and voiced that he was not sure why it was not working during the initial kitchen walkthrough. PR confirmed that once the start button is pressed, the dishwasher temperature gauge should start increasing in temperature and fluctuating throughout the cycle, but it should not go below the recommended temperature setting of 120 . DA confirmed that the temperature gauge did not move at all during the wash cycle during the initial kitchen walkthrough and it stayed at 100 the entire time. PR stated he could not recall when he last came to the facility to do preventative maintenance on dishwasher.At 12:00 PM, reviewed dishwasher temperature daily log for the months of October, November, and December of 2025, and for both AM/PM temperatures noted the temperature to be documented consistently at 125 . On 02/27/26 at 02:00 PM, review of the facility's Sanitation, policy, under the Cleaning and disinfection of utensils, dishware, pots, and pans section, it notes, When a chemical dish machine is utilized, the above items will be washed at a minimum 120 F using soap or detergent.NOTE: A preventative maintenance schedule shall be maintained and documented. Water temperatures will be monitored and documented daily. In the Equipment and supplies section, it reads, 1. Equipment used for cleaning of food and for proper dishwashing shall be maintained in working order. A preventative maintenance schedule shall be maintained and documented.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to assure staff treated one of one resident, Anonymous Resident (AR)1, with respect and dignity when caring for them while providing care with Activities of Daily Living (ADLs). This deficient practice has the potential to affect all residents in the facility who require assistance with ADLs. Findings Include:On 02/24/26 at 02:20 PM a family interview was conducted with AR1's representative. Inquired if AR1 was treated with respect and dignity and AR1's representative stated sometimes the staff talk rough to AR1. AR1's representative stated they tell staff that they are talking rough to AR1 when they witness this. Inquired if they told the unit manager or Director of Nursing and the resident representative said they did not, they chose to say something directly to the staff who was talking rough with AR1 at the time it occurred. Inquired what happens afterwards and the representative said the staff stops talking. Resident representative stated they are afraid for AR1, worried that this behavior might be happening when AR1's representative is not at the facility. Inquired the staff's name but AR1's representative was unable to state the staff's name. During this interview inquired of AR1 if they felt safe in the facility and they confirmed they did. On 02/27/26 at 11:51 AM in the conference room inquired of the Acting Director of Nursing (DON) if there has been reports of staff talking rough with the residents and she stated yes and it's in the reports, At this time reviewed event report that occurred on 07/31/25 when a resident reported a staff member was rough during care and ignoring her when she pressed her call light. DON investigated and found Certified Nursing Assistant (CNA) had worked with resident, provided care and shortly after the resident called her and CNA reported she rounded with her other residents first and then went back to her. Resident requested education for CNA and verbalized that she wanted to continue to work with this CNA. Unable to interview this resident as she was discharged to the hospital on [DATE]. Inquired of Acting DON if staff are to treat residents with respect and dignity, she confirmed this. Review of facility policy titled Resident Rights - Freedom From Abuse, Neglect & Exploitation with a reviewed and revised date of 04/11/18 states, Name of facility shall assure that all residents are fully aware of and able to exercise their rights during their stay at this facility and are treated by staff members, family members, friends, visitors and other residents in accordance with the rights to which they are entitled under applicable Federal and State regulations. Procedure for preventing resident abuse . 8. Any use of oral, written or gestured language, including disparaging and derogatory terms a resident to a resident that can result in intimidation, threat, harm, mental anguish and fear. Describing residents in a derogatory way regardless of their age, ability to comprehend or degree of disability is also prohibited. (Verbal Abuse)

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were informed of their right to formulate an Advanced Health Care Directive (AHCD) for two of six residents (Resident (R) 64 and R4) reviewed for AHCD. This failure placed R64 and R4 at risk of not having their health care preferences known or honored, potentially resulting in care that is not consistent with their wishes. Findings Include: 1) R64 was admitted to the facility on [DATE] with diagnoses including, but not limited to, peripheral vascular disease, type 2 diabetes mellitus with hyperglycemia, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, venous insufficiency, atherosclerotic heart disease of native coronary artery without angina pectoris, cardiomyopathy, chronic obstructive pulmonary disease, polyneuropathy, epilepsy, acquired absence of right leg and left leg above the knee, hypertension, and hyperlipidemia. Review of R64's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/12/25, documented a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident was cognitively intact. Review of R64's Electronic Health Record (EHR) revealed no AHCD on file. On 02/25/26, a request was made to the facility for a copy of R64's AHCD. On 02/26/26, the facility provided a Social Services progress note dated 12/12/25 documenting that R64 was oriented to person, place, time, and circumstances. The note stated: Resident does not wish to designate POA [Power of Attorney] at this time, wishes to continue to make her own decisions. POLST is Full Code, no change requested to plan of care. On 02/26/26 at 10:07 AM, an interview was conducted with R64. R64 stated that someone came quarterly to ask about her POLST. She reported that she had expressed a desire to change it to Do Not Resuscitate (DNR) and had requested the paperwork. R64 stated that no one had asked her about formulating an AHCD and that she did not know what it meant to formulate one. R64 further stated she would like to complete an AHCD and designate her daughter to assist with healthcare decisions if she becomes incapacitated. On 02/26/26 at 10:53 AM, an interview was conducted with Social Services Aide (SSA) 1. During concurrent review of the progress note, SSA1 confirmed that designating a POA is not the same as offering, educating, and formulating an AHCD. 2) R4 is a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis metabolic encephalopathy, muscle weakness, and pneumonitis. On 02/24/26 at 01:00 PM, reviewed R4's Electronic Health Record (EHR). There was no Advance HealthCare Directive (AHCD) or supporting documentation about formulating or obtaining an AHCD found in the progress notes or Care Plan (CP). (continued on next page)

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/25/26 at 01:00 PM, a copy of the AHCD and/or supporting documentation for R4 was requested from the Administrator. On 02/26/26 at 11:00 AM, no documentation was received. Concurrent interview with Social Services Aide (SSA) 1 confirmed that the AHCD was not completed for R4. On 02/27/26 at 11:44 AM, review of the facility's Residents' Rights Regarding Advance Directive policy dated, 12/2025, it reads, It is the policy of this facility to support and facilitate a resident's rights to request, refuse, and/or discontinue medical or surgical medical treatment and to formulate advance directives. In the Policy Explanation and Compliance Guidelines section, it reads, 1. On admission, the facility will determine if the resident has executed and advance directive, and if not, determine whether the resident would like to formulate an advance directive.

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, 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 onˆduty 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 (continued on next page)

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	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.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review and interview the facility failed to develop a care plan for bed rail use for one of six residents sampled for accidents, Resident (R) 38. The deficient practice puts all residents in the facility who have bed rails and do not have a care plan for bed rail use at risk for injury.Findings Include:On 02/25/26 at 09:05 AM observed R38 lying in her bed with bilateral upper quarter bed rails up on her bed. Inquired of R38 about the bed rails and she said she uses if she needs to hold onto it and the staff use it.Record review of R38's Electronic Health Record on 02/25/26 found R38's care plan did not include use of bilateral upper quarter bed rail use.Interview with Acting Director of Nursing (DON) on 02/27/26 at 10:42 AM was conducted in the conference room. Inquired of Acting DON if R38 had a care plan for bed rail use and she confirmed resident did not have a care plan in place for bed rail use and confirmed this should have been included.

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure one of three residents (Resident (R) 63) sampled for limited range of motion (ROM) received the appropriate treatment, equipment, and services to maintain and/or prevent a decline in ROM, as evidenced by inconsistent application of splint and ROM exercises. This puts R63 at risk of a decline in ROM and further contractures.Findings Include:R63 is a [AGE] year-old male, admitted to the facility on [DATE] with a primary diagnosis of dysphagia following cerebral infarction. On 02/24/26 at 08:28 AM observed R63 with right (R) hand and R foot contracture. No splint applied to R hand/R foot. At 10:32 AM, no splint applied to R hand/R foot. AT 01:07 AM, no splint applied to R hand/R foot.On 02/25/26 at 07:33 AM, no splint applied to R hand/R foot.On 02/25/26 at 01:00 PM record review of R63's Electronic Health Record (EHR) noted orders to assist R63 to wear splint (R hand and R foot splint) for 4 hours minimum as tolerated daily from 07:15-15:15. The Care Plan (CP) approach noted for R63 to perform ROM exercises to upper body and lower body 2-3x/week as tolerated and to continue donning soft ankle foot orthosis and resting hand splint 4 hours minimum.On 02/26/26 at 09:00 AM, observed R63 in bed with no R hand/R foot splints applied. On 02/26/26 at 09:15 AM, interview with Restorative Nurse Aide (RNA) confirmed that R63 should have splints applied. RNA stated that she did not get to apply the splints because of being busy doing certified nurse aide's (CNA) job when the facility is short. RNA also stated that CNAs and license staff can also apply splints. RNA also confirmed that she has only been able to provide R63 active/passive ROM once a week. RNA acknowledged the importance of applying splints and performing ROM exercises to help prevent further contractures.On 02/26/26 at 09:50 AM, interview with Acting Director on Nursing (DON) and Registered Nurse (RN) 1 confirmed that R63 should have had splints on and confirmed that according to R63's CP, he should have been getting 2-3x q week restorative nursing treatments. On 02/26/26 at 11:30 AM, record review of R63's restorative treatment records noted that he only had once a week treatment on 01/29/26, 02/06/26, 02/15/26, 02/19/26, and 02/25/26. Records also showed splints were not applied on 02/08-02/11, 02/13-2/14, and 02/22-02/24/26.Review of the facility's Restorative Nursing Programs policy, it notes in the Definition: Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. In the Policy Explanation and Compliance Guidelines: 2. The interdisciplinary [NAME], with the support and guidance from the physician, will assure the ongoing review, evaluation, and decision making regarding the services needed to maintain or improve the resident's abilities in accordance with the resident's comprehensive assessment, goal, and preferences. 4. All residents will receive maintenance nursing.as needed, by certified nursing assistants.5. Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for restorative nursing services. These services include a. Passive or active range of motion. B. Splint or brace assistance. 10. Restorative aides will implement the plan for a designated length of time, performing the activities, and documenting on the Restorative Aide Documentation Form.

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to monitor one resident's fluid intake for one of one resident sampled for dialysis, Resident (R) 6. This deficient practice put R6 at risk for fluid overload and complications with his dialysis. Findings Include:On 02/25/26 record review of R6's Electronic Health Record revealed R6 was readmitted to the facility on [DATE] and receives dialysis three times a week on Tuesday, Thursday, and Saturday. R6 was ordered a Renal diet; puree texture consistency; Thin liquid (Fluid restriction 1200 mL/day). Review of meals and fluid intake found the Certified Nursing Assistants (CNAs) documented this at each meal for R6. Review of R6's Medication Administration Record (MAR) found there was no monitoring of R6's fluid intake with medication administration. On 02/25/26 at 03:25 PM interviewed Licensed Practical Nurse (LPN)3 at the nurse's station. Inquired about R6's fluid restriction. Inquired how nurses know how much fluid he drinks each day. LPN3 stated resident has fluids measured out and provided with his meals and medication pass. On 02/27/26 at 11:37 AM interviewed Acting Director of Nursing (DON) in the conference room. Inquired if a resident is ordered fluid restriction if the resident would have his fluids documented with each medication pass and she confirmed a resident who is on fluid restrictions would be monitored and this information documented. Reviewed resident's MAR with the Acting DON and she stated R6's order for fluid restriction monitoring was discontinued on 02/12/26 when he was discharged to the hospital. Acting DON stated the resident returned to the facility on [DATE] and there was no new order to start monitoring his fluid intake from that time and this should have been ordered when he returned.

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to assess the risk of entrapment from bed rails prior to installation for two of two residents reviewed for accident hazards, Resident (R) 56 and R38. This deficient practice could place R56 and R38 at risk for harm from bed rail use. The deficient practice could affect all residents in the facility who are using bed rails if a risk assessment is not completed prior to use of their bed rails. Findings Include:Cross-reference to F909 Resident Bed. The facility failed to implement a regular maintenance program to identify areas of possible entrapment with bed rail use for residents observed using bed rails, Resident (R) 56 and R38. 1) On 02/24/2026 at 10:15 AM R56 was observed lying in her bed with bilateral upper quarter bed rails up on her bed.On 02/25/2026 during record review, of R56's Electronic Health Record (EHR), found she is [AGE] years old and her last admission occurred on 12/05/2024. R56's diagnoses include, but are not limited to, unspecified dementia, unspecified severity, with agitation and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Continued record review found R56 has a signed consent by her son for use of bed rails, alarms and call light which was signed on 07/10/19. Review of R56's Minimum Data Set (MDS) submitted on 12/04/2025 with an Assessment Reference Date (ARD) Observation end date of 11/18/2025 revealed R56 was coded as requiring substantial/maximal assistance when rolling left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed. Reviewed R56's care plan and found a care plan for bed rail use that stated, Placed side rail padding/pillows and frequent checks to ensure that any part of body is not in between rail and mattress/bed and gaps in the bedrail. Reviewed assessments completed for R56 and found there was no risk assessment completed for bed rail use. On 02/27/2026 at 10:42 AM interviewed Acting Director of Nursing (DON) in the conference room. Inquired if residents with bed rails needed a risk assessment to be completed prior to use of bed rails and Acting DON confirmed this. Inquired if R56 had one completed and she confirmed R56 did not have a risk assessment completed for bed rail use and this should have been done prior to using bed rails with R56. 2) On 02/25/2026 at 9:05 AM R38 observed lying in her bed which has bilateral upper quarter bed rails which were up in use. Inquired of R38 about the bed rails and she said she uses it if she needs to hold onto it and the staff use it.On 02/25/2026 at 3:05 PM interviewed Licensed Practical Nurse (LPN)3 at the nurse's station. Inquired about R38's bedrails and LPN3 stated R38 uses the bed rails to help with repositioning in her bed. On 02/25/2026 record review of R38's EHR found she is [AGE] years old and her last admission occurred on 02/03/2026. R38's diagnoses include, but are not limited to, acute diastolic (congestive) heart failure, chronic obstructive pulmonary disease, unspecified, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Continued record review revealed R38 has a signed consent for use for grab bar or assist rail dated 02/03/2026.Reviewed assessments completed for R38 and found there was no risk assessment completed for bed rail use. On 02/27/2026 at 10:42 AM interviewed Acting DON in the conference room. Inquired if R38 had a risk assessment completed for bedrail use and she confirmed resident did not have a risk assessment completed prior to bedrail use.

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 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 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 (continued on next page)

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medication carts were locked and under direct observation of authorized staff in an area where residents could access it for one of four medication carts observed. This practice does not ensure the protection and control of medications. Findings Include: On 02/26/26 at 10:12 AM, after exiting a resident's room, an unlocked medication cart was observed in the Ewa Unit hallway and left unattended. Facility staff were observed walking by the cart, and residents in wheelchairs were present in the hallway at the time.At 10:13 AM, Registered Nurse (RN)5 was observed walking from the Diamond Unit while carrying a pitcher of water. RN5 briefly spoke with another staff member while walking past the nurse's station to the Ewa Unit, not at direct observation of the medication cart. RN5 then introduced herself and confirmed that the medication cart was assigned to her. She stated that she had stepped away from the cart and acknowledged that it should have been locked.Review of the facility's policy and procedure Medication Storage dated 12/2025, documented under general guidelines, All drugs and biologicals will be stored in locked compartments .During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation and interview the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for two of two residents reviewed for accident hazards, Resident (R) 56 and R38. The deficient practice puts all residents at risk for possible entrapment if they have bed rails and they are not inspected and maintained according to manufacturer's recommendations and requirements.Findings Include:1) On 02/24/2026 at 10:15 AM R56 was observed lying in her bed with bilateral upper quarter bed rails up on her bed. 2) On 02/25/2026 at 9:05 AM R38 was observed lying in her bed with bilateral upper quarter bed rails which were up in use. Inquired of R38 about the bed rails and she said she uses it if she needs to hold onto it and the staff use it.On 02/27/2026 at 10:55 AM interviewed Maintenance Supervisor in the conference room. Inquired if he or his staff do routine maintenance for the residents' bed rails and have logs of this and he stated they, tighten the bolt if it is loose but do not have logs of this work. Inquired if he does anything else and he said no.