STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palolo Chinese Home	2459 10th Avenue Honolulu, HI 96816

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, interviews, and record review, the facility failed to ensure that residents were free from abuse by failing to adequately protect one of three residents reviewed for abuse allegations (R) 12). Specifically, a staff member willfully pushed R12's head without a care related purpose. This failure placed residents at risk of abuse and harm.Findings Include: Cross reference to F609, Reporting of Alleged Violations. The facility failed to ensure that a staff member who witnessed an incident involving another staff member willfully hitting a resident in the head immediately reported the incident to the administrator. On 05/04/26, the facility submitted a completed event report to the State Agency (SA), Intake #2999087. The report documented that on 04/21/26, between approximately 7:00 PM and 8:00 PM, Certified Nurse Aide (CNA) 30 reportedly witnessed CNA19 strike R12 twice on the head, once on the back of the head and once on the side of the head. According to the report, CNA30 was in the room assisting R12's roommate and .reported hearing the resident and .[CNA19] .engaging in a back-and-forth conversation; however, was unable to determine the content or subject of the discussion. Following this, .[CNA30] .witnessed the incident, which subsequently ceased [CNA30] .assisted .[CNA19] .in transferring resident [R12] back to bed [CNA30] .checked on him later, and the resident stated he was okay. The report also documented that CNA30 demonstrated what she witnessed and that R12 stated CNA19 had slapped him the previous week. The facility interviewed CNA19, who stated she used one finger to push the back of R12's head one time. CNA19 reported that the resident had been assisted to the toilet at his request and remained there for approximately 35 minutes without urinating or having a bowel movement. CNA19 stated that the resident's lack of output, combined with the difficulty of transferring him back to bed, led to her frustration and the incident.Review of the facility's completed investigation file showed that the facility interviewed R12 after becoming aware of the allegation on 04/29/26. Documentation indicated, Resident stated the staff member .[CNA19] .hit him on the back and side of his head. On 05/21/26 at 10:51 AM, a telephone interview was conducted with CNA30. CNA30 confirmed she witnessed CNA19 hit R12 on the back and side of the head with an open hand. CNA30 stated the force was enough to cause R12's head to jerk forward slightly and produce an audible sound, but not enough to cause him to fall. CNA30 reported she directly witnessed the incident and stated CNA19 stopped and looked at her immediately afterward. CNA30 stated that after the incident she offered to assist CNA19 with transferring R12. Although she did not discuss with CNA19 what had occurred, CNA30 reported she later asked R12 if he was okay after CNA19 left the room. On 05/21/26 at 11:46 AM, a telephone interview was conducted with CNA19. CNA19 stated she pushed R12's head with her pointer finger and did not slap him. CNA19 reported that she was joking with R12 because they had a good relationship. CNA19 stated that after assisting R12 to the bathroom, where he did not urinate or have a bowel movement, she told him not to ask to be taken to the bathroom if he did not need to use it.On 05/21/26 at 12:40 PM, an interview was conducted with R12. R12 stated that CNA19 slapped him. R12 reported he was shocked by the incident because he had a good relationship with CNA19. Although R12 stated he had difficulty recalling all the details of the incident, he recognized that CNA19's actions had made him sad and confused. On 05/21/26 at 11:23 AM, an interview was (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with the Infection Preventionist (IP). The IP stated that after receiving CNA30's report of the incident, she immediately interviewed R12 regarding what had occurred. The IP stated R12 was able to describe being slapped on the back and side of the head by CNA19 without prompting, consistent with CNA30's report. On 05/22/26 at 8:53 AM, an interview was conducted with the Director of Nursing (DON). When asked whether it was appropriate for CNA19 to push R12's head with her pointer finger, the DON stated CNA19 should not have placed her hands on the resident because the action was not related to providing care. The DON confirmed the incident was considered physical abuse. On 05/22/26 at 9:27 AM, an interview was conducted with the Administrator and Assistant Administrator. The Administrator and Assistant Administrator confirmed that, following completion of the facility's investigation, the facility concluded physical abuse had occurred. They stated this determination was based on CNA19's admission that she pushed the resident's head with her finger and the consistent accounts provided by CNA30 and R12 regarding the incident.Review of the facility's policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, last reviewed on 02/26/24, stated: Physical Abuse includes but is not limited to, hitting, slapping, punching, kicking or controlling behavior through corporal punishments. Corporal punishment, which is physical abuse includes, but not limited to, punching spanking, slapping hands, flicking, or hitting with an object. The policy further stated, Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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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. Based on interview and record review, the facility failed to ensure that a staff member who witnessed an incident involving another staff member willfully hitting a resident in the head immediately reported the incident to the administrator for one of three residents (Resident (R) 12) reviewed for allegations of abuse. This failure had the potential to delay the facility's response to allegations of abuse and place residents at risk for harm.Findings Include: Cross reference to F600, Free from Abuse and Neglect. The facility failed to ensure that R12 remained free from abuse when a staff member was witnessed willfully pushing/hitting the resident's head without a care-related purpose. On 04/29/26, the facility submitted an initial event report to the State Agency (SA), Intake #2999087. The report documented that on 04/21/26, between approximately 7:00 PM and 8:00 PM, Certified Nurse Aide (CNA) 30 reportedly witnessed CNA19 strike R12 twice on the head, once on the back of the head and once on the side of the head. The facility's report revealed that the incident occurred on 04/21/26 but was not reported to the SA until 04/29/26, eight days after the alleged incident.Review of the facility's completed investigation file showed that the facility interviewed CNA30, the witness, and the Infection Preventionist (IP). Documentation indicated that CNA30 did not report the incident immediately because she feared retaliation from CNA19.On 05/21/26 at 10:51 AM, a telephone interview was conducted with CNA30. CNA30 confirmed she witnessed CNA19 hit R12 in the back and side of the head. CNA30 stated that she did not report the incident immediately because CNA19 had assisted her with housing and was a contract staff member. She expressed concern that reporting the incident could negatively affect her living situation if retaliation occurred. CNA30 stated that she ultimately reported the allegation to the IP on 04/29/26.On 05/21/26 at 11:23 AM, an interview was conducted with the IP. The IP stated that another staff member informed her on 04/29/26 that CNA30 had disclosed witnessing the incident. The IP reported that she instructed CNA30 to formally report the allegation and provide a written statement because the allegation involved potential resident abuse.On 05/22/26 at 8:53 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that staff are required to immediately report any suspicion of abuse and confirmed that CNA30 should have reported the incident as soon as it occurred. The DON acknowledged that CNA30 delayed reporting because she feared retaliation. The DON further confirmed CNA19 continued to work with R12 after the incident due to the delay in reporting. Review of the facility's nursing staff schedule from 04/21/26 through 04/29/26 revealed that CNA19 was assigned to provide care to R12 on 04/21/26, 04/22/26, 04/24/26, 04/25/26, 04/26/26, and 04/28/26.Review of the facility's policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, last reviewed on 02/26/24, stated: Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation, or misappropriation shall immediately report it to the Nursing Home Administrator. If an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or withing 24 hours) reported to the State Agency.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an agency staff (AS) 10 who was a full-time employee completed the required training and competency evaluation program, or a competency evaluation program approved by the State for certification within four months of hire for one of three facility-reported staff-to-resident abuse allegations reviewed (Intake #2659390). This failure had the potential to place residents at risk for inadequate care and abuse. Findings Include:On [DATE] at 10:36 AM, record review was done. Review of facility document titled, Agency Staff Checklist for Credentials with staff credentials and hire dates revealed no specific Start Date for NA10. C.N.A. Certification did not also include any License Number and Expiration Date for NA10 indicating not certified. On [DATE] at 11:12 AM, an interview was conducted with Administrator. Administrator confirmed that AS10, did not meet competency evaluation requirements or a certification for nurse aide. Administrator also stated that AS10 received on the job training for caregiver but would not be appropriate for the Long-Term Care program of the facility. Administrator explained that facility usually checks and requires certified nurse aide (CNA). Administrator agreed that AS10 should not have worked in the Long-Term Care facility. Review of facility document titled, Certified Nurse Aide (C.N.A. Job Description with an updated date of [DATE] stated, .Education and Training.Must have current CPR.and Hawaii CNA certification.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. Based on interview and record review, the facility failed to ensure that an agency staff (AS) 10 providing nurse aide services was listed on the state nurse aide registry prior to working in the facility for one of three facility-reported staff-to-resident abuse allegations reviewed (Intake #2659390). This deficient practice placed residents at risk for care being provided by unqualified staff and had the potential to affect resident safety and well-being. Findings Include:Cross reference to F0728 - Facility Hiring and Use of Nurse On 05/21/26 at 11:12 AM, an interview was conducted with Administrator. Administrator confirmed that AS10 did not meet competency evaluation requirements or a certification for nurse aide. Administrator also stated that AS10 received on-the-job training as caregiver but would not be appropriate for the Long-Term Care program. Administrator explained that the facility usually checks and requires complete education and training to include certified nurse aide (CNA) certification. Administrator agreed that SA10 should not have worked in Long-Term Care. On 05/21/26 at 09:19 AM, an interview with the Director of Nursing (DON) was done. When DON was queried if facility should verify nurse aide registry prior to hiring staff, DON confirmed and agreed.