STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	Initial Comments A re-licensure survey was conducted from 09/26/22 to 09/30/22. The facility census included 99 residents.	4 000		
4 105	11-94.1-22(g) Medical record system (g) All entries in a resident's record shall be: (1) Accurate and complete; (2) Legible and typed or written in black or blue ink; (3) Dated; (4) Authenticated by signature and title of the individual making the entry; and (5) Written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical doctor. This Statute is not met as evidenced by: Based on record review and interview, the facility failed to accurately document a rehabilitation maintenance program order for Resident (R) 4. This deficient practice has the potential to adversely affect the level of mobility for all residents who are ordered a rehabilitation maintenance program. Findings include: On 09/29/22 at 10:32 AM, a review of R4's medical record indicated a physician's order dated 06/14/19 which stated, "PT (physical	4 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 105	Continued From page 1 therapy) evaluation completed. Skilled PT not indicated, continue with rehab maintenance program 5x/week." A review of R4's care plan stated, "Problem: Decreased Range of Motion ...Interventions 7) Rehab will provide maintenance program 2-3x/wk ...initiated 06/13/19." On 09/29/22 at 11:11 AM, a concurrent interview and record review was done with Physical Therapist (PT) 1. PT1 reviewed R4's PT order and stated that the order was inaccurate and that R4 receives a rehabilitation maintenance program two to three times a week instead of five times a week. PT1 reviewed R4's care plan and stated that the order should have been revised to match R4's care plan for receiving a rehabilitation maintenance program two to three times a week.	4 105		
4 114	11-94.1-27(3) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (3) The right to be fully informed, both orally and in writing in a language understood by the resident, or in a manner that allows for the resident's understanding, of the resident's rights and all rules and regulations governing resident conduct and responsibilities;	4 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 114	Continued From page 2 This Statute is not met as evidenced by: Based on observations, record review, interviews, and facility policy review, the facility failed to ensure staff consistently informed a resident of care and services to be provided in a language the resident understood, to promote the resident's right to be fully informed of his/her total health status, for 1 (Resident #14) of 3 sampled residents reviewed for communication. Findings included: Review of a facility policy titled, "Communication with Persons with Limited English Proficiency," dated 11/01/2010, revealed, "Language assistance will be provided through use of competent bilingual staff, staff interpreters, contacts, or formal arrangements with local organizations providing interpretation or translations services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP [limited English proficiency] individuals will be trained in effective communication techniques, including effective use of an interpreter." The policy also indicated, "3. Family members or friends of the LEP will not be used as interpreters unless specifically requested by that individual and after the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. a. Such an offer and the response will be documented in the person's chart." Review of an "Admission Record" revealed the facility admitted Resident #14 on 06/17/2022 with diagnoses that included Alzheimer's disease, anxiety disorder, and insomnia.	4 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 114	Continued From page 3 Review of an admission Minimum Data Set (MDS), dated 06/24/2022, revealed Resident #14 scored zero on a Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The MDS indicated the resident had clear speech, was sometimes understood, and sometimes understood others. Review of a "CAA [Care Area Assessment] Worksheet," dated 09/24/2022, revealed Resident #14 had a decreased ability to make him/herself understood and/or to understand others. The worksheet noted there was a risk for frustration and isolation if the resident was unable to make him/herself understood or to fully understand information. Review of a care plan, dated as initiated on 06/21/2022, revealed Resident #14 was at risk of communication difficulty exacerbated by Dementia and minimal English. The goal was for the resident to be able to communicate his/her needs via an interpreter and visual communication board. A planned intervention was for staff to utilize a communication chart and/or use interpreter help as needed. During an observation on 09/29/2022 at 11:00 AM, Resident #14 was attempting to stand up; two staff members attempted to assist but were unable to determine what Resident #14 wanted. Resident #14 became agitated. Licensed Practical Nurse (LPN) #1 stated staff had to guess what Resident #14 wanted, since they could not understand the resident. During an observation on 09/30/2022 at 9:00 AM, Nurse Manager (NM) #5 spoke to Resident #14 in	4 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 114	Continued From page 4 English, asking the resident to remove his/her belt and attempting to explain to the resident that NM #5 was checking the alarm on the belt to ensure it worked. During an interview on 09/29/2022 at 10:01 AM, Certified Nursing Assistant (CNA) #1 stated that sometimes Resident #14 shouted because staff could not understand him/her. CNA #1 stated staff tried their best with gestures, and if they needed help, there was a Registered Nurse (RN) who spoke the resident's language. CNA #1 stated that when the RN was not working, staff just did the best they could. During an interview on 09/29/2022 at 10:52 AM, LPN #1 stated Resident 14 was alert but did not speak English. LPN #1 stated since she did not speak the resident's language, it was tough to communicate, and she used gestures. LPN #1 stated there was a situation where Resident #14 was agitated while staff were attempting to bathe the resident. LPN #1 stated they were unable to communicate with Resident #14 in his/her language, and LPN #1 thought that was why Resident #14 became agitated. During an interview on 09/29/2022 at 12:53 AM, Social Worker (SW) #1 stated the facility had the phone number for a language interpreter line and picture boards in various languages. SW #1 stated she gave the staff the information and that Resident #14 had a communication board. During an interview at 09/29/2022 at 1:37 PM, NM #5 stated there were iPads available in the facility to assist with translation. Additionally, there was translator, and a staff member was sometimes utilized to translate for the resident. NM #5 stated she had called Resident #14's	4 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 114	Continued From page 5 family member to interpret at times. NM #5 stated staff should have been aware of the translation options. During an interview on 09/29/2022 at 3:22 PM, CNA #2 stated it was hard to take care of Resident #14 because the resident did not speak English. CNA #2 stated he used body language to figure out what Resident #14 was talking about. CNA #2 stated Resident #14 would speak to him, and he did not know what the resident was saying. During an interview on 09/30/2022 at 9:11 AM, Unit Clerk #1 stated Resident #14 got frustrated when he/she could not express him/herself, because staff did not understand what the resident was saying. During an interview with the Administrator and Director of Nursing (DON) on 09/30/2022 at 2:43 PM, the Administrator stated the facility had communication boards and a language line interpreter that could be called. The Administrator stated staff were educated on this at the annual education fair. The DON stated Resident #14 did not speak English. The DON stated there was a phone interpretation service, pictures that could be pointed to, and machines that could be put in place. The DON stated staff was educated at the annual education fair, and there were signs on the desks with information as well.	4 114		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's	4 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 115	Continued From page 6 stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observations, record review, interviews, and facility policy review, the facility failed to ensure an assessment was completed to determine if a chair alarm and seat belt were medically necessary, safe, and appropriate for 1 (Resident #14) of 1 sampled resident reviewed for restraints. Findings included: Review of a facility policy titled, "Physical Restraints and Devices," dated 03/06/2008, revealed the following: - "Definitions: A physical restraint is any manual method or physical or mechanical device, material, or equipment that is attached or adjacent to the resident's body that the resident cannot easily remove by him/herself and restricts the resident from freedom of movement or normal access to his/her own body." - Procedure: A. Responsibilities: 1. The Nursing staff shall: a. Determine through documented assessment that the device is needed to improve the resident's well being [sic], is medically	4 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 115	Continued From page 7	4 115		

necessary, and its benefits outweigh potential harmful effects. b. Select a restraint to be used only after other less restrictive measures have been found to be ineffective to protect the resident from harm."

- B. Assessment/Care Planning: 1. A THREE-DAY ASSESSMENT PERIOD shall be implemented upon admission or use of new device that may be considered a physical restraint to determine if the resident requires the device to ensure resident's safety, increase function and/or to complete a medical treatment. 2. During the THREE-DAY ASSESSMENT PERIOD: a. The Nurse shall observe and assess the resident for risk for falls or injury. b. The observations and assessment must be documented in the Interdisciplinary Progress Notes (IPN) every shift. c. Documentation to include medical condition, functional ability, medications, cognitive status and psychological impact related to use of the device/restraint. d. The nurse will utilize alternatives for restraint use and document interventions tried."

- "5. After less restrictive devices or alternatives have been tried and found ineffective in protecting the resident from harm, the Nurse will: a. Complete the Restraint Assessment/RAP Review form on the computer for each device. Print a copy, sign and file in chart. b. Determine if the device is a restraint or not on page 2 of the form.

Review of an "Admission Record" revealed the facility admitted Resident #14 on 06/17/2022 with diagnoses that included Alzheimer's disease, anxiety disorder, and insomnia.

Review of an admission Minimum Data Set

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 115	Continued From page 8 (MDS), dated 06/24/2022, revealed Resident #14 scored zero on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The MDS indicated the resident required extensive assistance for transfer, was totally dependent for locomotion, and used a wheelchair for mobility. According to the MDS, the resident used a bed and chair alarm daily and used no restraints. Review of a care plan, dated as initiated 06/17/2022 and revised 08/05/2022, revealed Resident #14 was at high risk for falls related to incontinence, vision/hearing problems, antihypertensive medication, and psychoactive medication. Interventions included a Posey alarm with splitter while in bed, so the call light was activated if the resident tried to get up unassisted; and a wheelchair Posey alarm with a speaker, to remind the resident to sit and wait for help, to be on at all times when the resident was in the wheelchair. Review of a "Progress Note," dated 07/05/2022 at 1:54 PM revealed the resident kept insisting on going home and trying to get out of the wheelchair and "going down to floor." The nurse noted that she called the resident's family member and left a message. Review of a "Progress Note," dated 07/05/2022 at 2:33 PM, revealed the nurse obtained verbal permission from the resident's family member to apply a seat belt when the resident was sitting in the wheelchair. During an observation on 09/29/2022 at 10:15 AM, Resident #14 was sitting in a wheelchair with a Velcro waist belt applied. During an observation on 09/29/2022 at 2:04 PM,	4 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 115	Continued From page 9 Nurse Manager (NM) #5 asked Resident #14 if he/she could remove the Velcro belt. The resident was confused and stated he/she did not want to take it off and that it belonged to him/her. During an observation on 09/30/2022 at 9:00 AM, NM #5 asked Resident #14 to remove the belt and the resident was able to remove it. The alarm did not sound. NM #5 stated it was supposed to have a recording that remined the resident, "The nurse is here to help." NM #5 stated the alarm was not activated when Resident #14 removed the belt. During an interview on 09/29/2022 at 10:01 AM, Certified Nursing Assistant (CNA) #1 stated Resident #14 had a seatbelt when in the wheelchair. CNA #1 stated Resident #14 had it because he/she would try to stand up, and it stopped the resident from standing. CNA #1 stated Resident #14 knew how to open the belt and that it was a reminder. During an interview on 09/29/2022 at 1:22 PM, Licensed Practical Nurse (LPN) #1 was not sure when the Velcro belt was put in place or whether other interventions were tried before implementing the belt, but stated that Resident #14 knew how to turn off the alarm. During an interview on 09/29/2022 at 1:43 PM, NM #5 stated was not sure if there was a documented evaluation done to determine if the Velcro belt was a restraint for Resident #14. During an interview on 09/30/2022 at 3:26 PM, the Director of Nursing (DON) stated that when a resident had a device put in place that could potentially be a restraint, the resident would be assessed for the need for the device. The DON	4 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 115	Continued From page 10 stated there was a paper assessment that was included in the facility policy. The DON stated he/she would have to read the policy to know if an assessment should have been done for Resident #14's potential restraint. During an interview on 09/30/2022 at 3:26 PM, NM #5 stated no assessment was done for Resident #14's Velcro belt. During an interview on 09/30/2022 at 3:26 PM, the Administrator stated the facility had an assessment to determine if a resident needed a device, assess whether the resident could remove it, and indicate the goal of the device. The Administrator stated the facility needed to do the assessment to rule out a device being considered a restraint.	4 115		
4 118	11-94.1-27(7) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (7) The right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive; □ This Statute is not met as evidenced by: Based on record review, interviews, and facility	4 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 118	Continued From page 11 policy review, the facility failed to ensure a resident's code status was addressed in the current physician's orders in the electronic medical record to facilitate staff's ability to honor the resident/responsible party's wishes for 1 (Resident #27) of 1 sampled resident whose request for "do not resuscitate (DNR)" status was reviewed. Findings included: Review of a policy titled, "Provider Orders for Life-Sustaining Treatment (POLST)," dated 06/23/2016, revealed a "Code Status Order Form," which indicated, "This order must be completed and signed by the attending physician and filed in the patient's/resident's chart at all times." The form also indicated, "Note to Physicians: The current code status must be documented in physician's orders and physician's progress notes with details." Review of an "Admission Record" revealed Resident #27 had diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting unspecified side, impulse disorder, and hypothyroidism. The "Advance Directive" section of the "Admission Record" was blank. Review of a quarterly Minimum Data Set (MDS), dated 07/05/2022, revealed the resident scored 15 on a Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact. Review of a care plan, dated as initiated 06/28/2022, revealed Resident #27 had "laid out" his/her wishes in an advance healthcare directive, in the event the resident became seriously ill,	4 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 118	Continued From page 12 unable to speak, and/or unable to make his/her own decisions. A planned intervention was to follow the resident's advance directive, POLST, and code status, which was indicated to be "DNAR [do not attempt resuscitation]." Review of a "Provider Orders for Life-Sustaining Treatment (POLST)" form, dated as signed by the resident's responsible party (RP) on 10/14/2020, revealed the resident's code status was, "Do Not Attempt Resuscitation/DNAR Allow Natural Death." Review of an "Order Summary Report," printed 09/29/2022, revealed Resident #27's current physician's orders did not include an order for code status. During an interview on 09/29/2022 at 10:17 AM, Nurse Manager (NM) #5 stated that once a POLST was signed, the nurses should carry it out, and there should be a physician's order for full code or DNR in the resident's orders. NM #5 stated that Resident #27's code status was changed to DNR in 2020. NM #5 was unable to locate an order for code status in the electronic medical record. During an interview on 09/29/2022 at 10:09 AM, Registered Nurse (RN) #3 stated a resident's code status could be found in the resident's profile in the electronic medical record and in the physician's orders. The RN stated every resident should have a code status order. During an interview on 09/30/2022 at 2:58 PM, the Director of Nursing stated a physician's order should have been entered for the resident's	4 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 118	Continued From page 13 POLST and that this was always "one of the main orders." During an interview on 09/30/2022 at 3:30 PM, the Administrator stated the POLST should have been put under the orders in the electronic medical record, so the code status would show in the chart.	4 118		
4 120	1-94.1-27(9) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (9) The right to names, addresses, and telephone numbers of pertinent resident advocacy groups; This Statute is not met as evidenced by: F577	4 120		
4 126	11-94.1-27(15) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including:	4 126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 126	Continued From page 14 (15) The right to translation or interpretation services or other communication assistance as necessary. This Statute is not met as evidenced by: F676	4 126		
4 131	11-94.1-29(b) Resident abuse, neglect, and misappropriation (b) All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source or origin, and alleged misappropriation of resident property shall be reported immediately to the administrator of the facility, and to other officials in accordance with state law through established procedures. This Statute is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure allegations of staff-to-resident abuse were immediately reported to the Administrator for 1 (Resident #14) of 1 sampled resident reviewed for abuse. Findings included: Review of a facility policy titled, "Prevention of Resident Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property," dated 11/03/2021, revealed, "All employees are required to report alleged complaints and/or violations involving abuse, neglect, involuntary seclusion, injury of unknown origin and misappropriation of property immediately to the Administrator and Director of Nursing (DON) of the facility. Such	4 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 131	Continued From page 15 complaints and violations shall be reported to the State agencies within specified timelines according to law." Review of an "Admission Record" revealed the facility admitted Resident #14 on 06/17/2022 with diagnoses that included Alzheimer's disease, anxiety disorder, and insomnia. Review of an admission Minimum Data Set (MDS), dated 06/24/2022, revealed Resident #14 scored zero on a Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Review of a "Progress Note," dated 07/15/2022, revealed the resident was being assisted in the bathroom by a Certified Nursing Assistant (CNA). The CNA was attempting to change the resident's soiled pants, and the resident got agitated and angry, accusing the CNA of hitting him/her. The note indicated the resident grabbed and pinched the CNA. Review of a "Progress Note," dated 09/03/2022, revealed two staff gave Resident #14 a shower. The resident accused the staff of taking his/her clothes off and pinching and hitting the resident. The note indicated, "Actually, resident was hitting and pinching staff." During an interview on 09/29/2022 at 8:20 AM, the DON stated there had been no allegations of abuse reported in the past six months. During an interview on 09/29/2022 at 10:52 AM, Licensed Practical Nurse (LPN) #1, who was one of the staff involved in the 09/03/2022 shower for Resident #14, stated if there was an allegation of abuse, it was to be reported to the charge nurse, social worker, and DON. The LPN	4 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 131	Continued From page 16 indicated on the day of the incident in the shower, the resident's allegation was reported to the charge nurse. During an interview on 09/29/2022 at 11:07 AM, Nurse Manager #5 stated Resident #14's behaviors included pinching and hitting. NM #5 stated the accused staff members reported that Resident #14 was the one doing the hitting, and NM #5 did not report the allegation because Resident #14 was the one who hit staff. NM #5 stated staff received annual training on abuse prevention and reporting. NM #5 stated staff needed to tell the supervisor about an allegation of abuse. NM #5 stated that if a resident complained that someone hurt them, pinched them, or punched them, it was expected that this would be reported. NM #5 stated a report of abuse was received, she would make sure the resident was safe, notify the DON and the Administrator, and remove the alleged perpetrator from resident care. During an interview on 09/29/2022 at 2:19 PM, the DON stated if a resident reported that a staff member hit or pinched them, it would be immediately investigated. The DON stated if a resident had a history of accusatory behaviors, every time they made an allegation, it would be thoroughly investigated. The DON stated Resident #14's abuse allegations were not reported. During an interview on 09/30/2022 at 1:39 PM, Registered Nurse (RN) #3 stated if a resident reported that someone hit or pinched them, it should be reported right away, and the accused person would be removed from the resident area.	4 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 131	Continued From page 17 During an interview on 09/30/2022 at 2:36 PM, NM #5 stated when Resident #14 stated two staff members were pinching him/her, the staff members reported that the resident had been pinching them. During an interview on 09/30/2022 at 3:15 PM, the Administrator stated there should have been an event report if a resident alleged that a staff member hit or pinched them, and it had to be investigated right away to rule out abuse. The Administrator stated the staff had to be separated and sent home until abuse was ruled out. The Administrator stated an allegation of abuse should be reported for a resident who was confused. The Administrator denied being aware of Resident #14's allegations and was not sure if they were reported and investigated.	4 131		
4 133	11-94.1-29(d) Resident abuse, neglect, and misappropriation (d) The facility shall maintain a record that all alleged violations were thoroughly investigated, and shall take all reasonable steps to prevent further abuse while the investigation is in progress. This Statute is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to investigate allegations of abuse and implement protective measures to prevent further potential abuse for 1 (Resident #14) of 1 sampled resident reviewed for abuse. Specifically, when Resident #14 alleged staff-to-resident abuse on two separate occasions, staff's failure to report the allegations	4 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 133	Continued From page 18 to the Administrator resulted in failure to initiate investigations and protective measures for Resident #14. Findings included: Review of a facility policy titled, "Prevention of Resident Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property," dated 11/03/2021, revealed, "All employees are required to report alleged complaints and/or violations involving abuse, neglect, involuntary seclusion, injury of unknown origin and misappropriation of property immediately to the Administrator and Director of Nursing (DON) of the facility. Such complaints and violations shall be reported to the State agencies within specified timelines according to law. Each incident will be thoroughly investigated and actions taken to prevent potential abuse while the investigation is in progress." The policy also indicated, "When any event occurs involving the health, welfare or safety of residents, including reports of suspected abuse, the following steps shall be taken by staff: 1. Immediately remove the resident to an appropriate environment necessary to protect the resident's safety. If the alleged perpetrator is a: a. Resident: Separate the residents so they do not have access to each other or until circumstances of the reported incident can be assessed and determined. B. Employee: Notify the employee of the allegation and immediately relieve the employee from duty and any contact with the resident and other residents. The employee is removed from direct resident care until the complaint or allegation is investigated." Review of an "Admission Record" revealed the facility admitted Resident #14 on 06/17/2022 with diagnoses that included Alzheimer's disease,	4 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 133	Continued From page 19 anxiety disorder, and insomnia. Review of an admission Minimum Data Set (MDS), dated 06/24/2022, revealed Resident #14 scored zero on a Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Review of a "Progress Note," dated 07/15/2022, revealed the resident was being assisted in the bathroom by a Certified Nursing Assistant (CNA). The CNA was attempting to change the resident's soiled pants, and the resident got agitated and angry, accusing the CNA of hitting him/her. The note indicated the resident grabbed and pinched the CNA. Review of a "Progress Note," dated 09/03/2022, revealed two staff gave Resident #14 a shower. The resident accused the staff of taking his/her clothes off and pinching and hitting the resident. The note indicated, "Actually, resident was hitting and pinching staff." During an interview on 09/29/2022 at 8:20 AM, the DON stated there had been no allegations of abuse reported in the past six months. During an interview on 09/29/2022 at 10:52 AM, Licensed Practical Nurse (LPN) #1, who was one of the staff involved in the 09/03/2022 shower for Resident #14, stated that if there was an allegation of abuse, it was to be reported to the charge nurse, social worker, and DON, and they must investigate. On the day of the 09/03/2022 incident, LPN #1 stated the allegation was reported to the charge nurse. LPN #1 denied being removed from duty that day. During an interview on 09/29/2022 at 11:07 AM,	4 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 133	Continued From page 20 Nurse Manager (NM) #5 stated staff received annual training on abuse prevention and reporting. The NM stated for allegations of abuse, staff needed to stop the abuse, protect the resident, oust the person that was being accused, and tell the supervisor. NM #5 stated if a resident complained that somebody hurt them, pinched them, or punched them, it was expected that this would be reported. NM #5 stated she would make sure the resident was safe, notify the DON and the Administrator (NHA), and remove the alleged perpetrator from patient care. Regarding Resident #14's allegations, NM #5 stated Resident #14's behaviors included pinching and hitting. NM #5 stated the allegations were not investigated or reported. NM #5 stated the accused staff members stated that Resident #14 was the one who was doing the hitting, and the allegation was not reported because Resident #14 was the one who hit staff. During an interview on 09/29/2022 at 2:19 PM, the DON stated if a resident reported that a staff member hit or pinched them, it would be immediately investigated. The DON stated if a resident had a history of accusatory behaviors, every time they made an allegation, it would be thoroughly investigated. The DON stated Resident #14's abuse allegations were not reported. During an interview on 09/30/2022 at 1:39 PM, Registered Nurse (RN) #3 stated if a resident reported that someone hit or pinched them, it should be reported right away, and the accused person would be removed from the resident area. During an interview on 09/30/2022 at 2:36 PM, NM #5 stated when Resident #14 stated two staff members were pinching him/her, the staff	4 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 133	Continued From page 21 members reported that the resident had been pinching them. During an interview on 09/30/2022 at 3:15 PM, the Administrator stated there should have been an event report if a resident alleged that a staff member hit or pinched them, and it had to be investigated right away to rule out abuse. The Administrator stated the staff had to be separated and sent home until abuse was ruled out. The Administrator stated an allegation of abuse should be reported for a resident who was confused. The Administrator denied being aware of Resident #14's allegations and was not sure if they were reported and investigated.	4 133		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by:	4 136		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	Continued From page 22 F604 and F689?	4 136		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure post-fall care was provided in accordance with accepted standards of nursing practice, as evidenced by	4 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 149	Continued From page 23 failure to consistently conducted neurological (neuro) checks after a fall for 1 (Resident #79) of 3 sampled residents reviewed for accidents. Findings included: Review of a facility policy titled, "Post Fall Monitoring," dated 06/09/2016, revealed, "Nursing staff will assess a patient/resident for injury following a fall event; and continue to monitor for a minimum of 72 hours or as long as necessary to ensure his/her condition is stabilized." The policy also indicated when a fall occurred, the steps staff were to take included the following: - "2. Nursing - Certified Nurses [sic] Aides/Licensed staff: a. Notify staff including charge/head nurse to assess and assist with resident's care. b. Assist resident back to bed only after evaluated by licensed nurse. c. Initiate post fall monitoring - vital signs, pain score, neuro checks, and orthostatic blood pressure." - 4. Subsequent shifts a. Continue monitoring resident's condition for the next 3 days and document status in the medical record and in Daily Nursing Report. B. Vital signs, including pain score, (and neuro checks if there is any possibility that resident may have struck head) as follows: Every 15 min. [minutes] for first hour; if stable then Every 30 min x [times] 2; if stable then every hour x 2; if stable then Every 4 hours x 5; if stable then Every 8 hours x 2 days." Review of an "Admission Record" revealed the facility admitted Resident #79 on 08/11/2022 with diagnoses including Parkinson's disease, dementia, and adjustment disorder with mixed anxiety and depressed mood.	4 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 149	Continued From page 24 Review of an admission Minimum Data Set (MDS), dated 08/18/2022, revealed Resident #79 scored 12 on a Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. The MDS indicated the resident required extensive assistance with bed mobility, and that walking and locomotion did not occur during the assessment period. According to the MDS, the resident did not have any falls in the past two to six months prior to admission. Review of an "Event Report Form," dated 09/06/2022 at 2:45 PM, revealed Resident #79 had an unattended fall from bed and was found on the floor. No injuries were notified. According to the form, hospice, the supervisor, the physician, and the resident's family were all notified. The form indicated neuro checks were initiated. Review of "Neurological Check List/Post Fall Monitoring" form in the electronic medical record indicated neuro checks were completed on 09/06/2022 at 10:40 PM. The next documented neuro checks were almost eight hours later, on 09/07/2022 at 6:02 AM. Further neuro checks were documented on 09/07/2022 at 6:30 AM, 10:34 AM, 2:30 PM, and 10:25 PM.; 09/08/2022 at 6:37 AM, 2:30 PM, and 7:58 PM; and 09/09/2022 at 7:36 AM and 1:44 PM. During an interview on 09/30/2022 at 8:46 AM, Registered Nurse (RN) #1 stated when a resident had an unwitnessed fall, neurological checks were completed every 15 minutes for the first hour after the fall, then every 30 minutes for two hours. The RN stated the neuro checks would automatically "come up" in the electronic medical record when it was time for the next check to be completed.	4 149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 149	Continued From page 25 During an interview on 09/20/2022 at 2:18 PM, the Director of Nursing (DON) stated when a resident had an unwitnessed fall, staff were to follow the facility's neurological check policy. During an interview on 09/30/2022 at 3:13 PM, the Administrator stated neuro checks had to be done for unwitnessed falls because there was no way to tell if a resident had hit their head. The Administrator indicated the frequency of the neuro checks was included in the facility's policy.	4 149		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: F812	4 159		
4 194	11-94.1-46(k) Pharmaceutical services (k) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.	4 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. BUILDING: _____ B. WING _____	09/30/2022

POC NOT FINAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAHI HOSPITAL	3675 KILAUEA AVENUE HONOLULU, HI 96816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 194	Continued From page 26 This Statute is not met as evidenced by: F755	4 194		
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: F761	4 197		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: F880	4 203		