STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125065	A. BUILDING: _____ B. WING _____	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HILO REHABILITATION & NURSING CENTER	563 KAUMANA DRIVE HILO, HI 96720

(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 On 09/15/22 a re-licensure survey was conducted in conjunction with the recertification survey. The recertification survey was conducted by CertiSurv on behalf of the Department of Health, Office of Health Care Assurance on 09/16/22. The facility was found not to meet the regulatory requirements for the Hawaii Administrative Rules, Title 11, Chapter 94.1, Nursing Facilties.	4 000		
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 interviews, record review, and facility policy review, the facility failed to report an allegation of misappropriation of resident property to local law enforcement within 24 hours for 1 (Resident #176) of 1 sampled resident reviewed for misappropriation. Findings included: Review of a facility policy titled, "Comprehensive Abuse Policy and Prevention," updated 03/03/2021, revealed, "7. Reporting/Responding: Abuse Policy Requirements: The facility must report alleged violations related to mistreatment, exploitation, neglect or abuse: including injuries of	4 131		

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4 131	Continued From page 1 unknown source and misappropriation of resident property and report the results of all investigations to the proper authorities within prescribed timeframes. Allegations must be reported to the Administrator/designee immediately. The Administrator/designee will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported no later than 2 hours after the allegation is made, if events that cause the allegation abuse [sic] or result in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the state survey agency and others (police, APS [Adult Protective Services], OIG [Office of the Inspector General], AG [Attorney General], etc. [et cetera]) [sic] will be notified as mandated by regulation and/as needed." Review of a "Face Sheet" revealed the facility admitted Resident #176 with diagnoses which included fracture of the left clavicle, chronic obstructive pulmonary disease, and dementia without behavioral disturbance. Review of an admission Minimum Data Set (MDS), dated 05/21/2022, revealed Resident #176 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. The MDS indicated the resident had disorganized thinking continuously; felt down, depressed, or hopeless on two to six days during the seven-day assessment period; and rejected care on one to three days during the seven-day assessment period. According to the MDS, Resident #176 required extensive assistance with bed mobility and transfer.	4 131		

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4 131	Continued From page 2 Review of a "Care Plan," dated as initiated on 05/23/2022, revealed Resident #176 had impaired cognition as evidenced by short-term deficits related to dementia. Interventions included to provide orientation and validation as needed. Review of a "Resident Grievance Investigation Report Form," dated 06/02/2022, revealed Resident #176 went into one of two wallets and had $40.00. Resident #176 indicated the other wallet contained $110.00 which was missing. According to the grievance form, Resident #176 believed "someone took the money." The resident had a key (to the bedside table drawer) but Social Services (SS) #1 checked the drawer and found it unlocked. The resident reported only having had one visitor, Friend #1, and the resident denied having given Friend #1 the $110.00. Resident #176 stated he/she gave Friend #1 his/her bank card because Friend #1 bought things for him/her. Additionally, the resident indicated he/she was allowing Friend #1 to use the resident's vehicle. Review of an "Office of Health Care Assurance Event Report," revealed the facility initially self-reported an allegation of misappropriation of resident property/funds for Resident #176 on 06/03/2022 at 3:20 PM. The date of the incident was documented as 06/02/2022 at 3:29 PM. The report revealed Resident #176 notified Social Services (SS) Employee #1 that he/she was missing $110.00 from his/her wallet. The report indicated there was no inventory of these funds upon admission. The resident still had $40.00 remaining in his/her wallet. According to the report, Social Services interviewed the resident, who stated the money was in one of two wallets he/she had locked in the bedside drawer. The	4 131		

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4 131	Continued From page 3 report indicated when SS #1 asked to see the wallets in the locked drawer, Resident#176 opened the drawer without a key. Resident #176 stated he/she had two wallets and had given his/her bank card and vehicle to Friend #1. Only one wallet was found in the drawer. The report indicated Resident #176 then stated that $110.00 was taken out of his/her account. According to the report, the inventory sheet completed upon admission in May 2020 indicated no wallet. The report indicated bank statements were reviewed with the resident and revealed no withdrawals during the resident's time at the facility. The report indicated the resident's physician was notified of the allegation on 06/02/2022, the responsible party was notified on 06/02/2022, and the Administrator was notified on 06/02/2022. The report revealed the police were not notified. Review of an "Office of Health Care Assurance Event Report," revealed the facility submitted the completed investigation regarding Resident #176's allegation to the state survey agency on 06/08/2022. The investigation indicated Emergency Contact #1 was contacted and stated he/she brought a wallet with $60.00 to the resident on an unknown date, and the resident was going to give $20.00 to Friend #1. According to the report, the emergency contact stated Resident #176 never had $110.00 in the wallet he/she delivered to the resident. The report indicated Friend #1 had not responded after multiple attempts to reach him/her about the resident's bank card and vehicle. The report indicated, "allegations unsubstantiated at facility as funds equal what [Emergency Contact #1's] statement identified." The report indicated Adult Protective Services (APS) was notified; however, the police were not notified.	4 131		

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4 131	Continued From page 4 During an interview on 09/15/2022 at 10:13 AM, Licensed Practical Nurse (LPN) #2 revealed she admitted Resident #176 on 05/16/2022 from the hospital. The resident had only four pieces of clothing and no money or wallet. She revealed she received abuse training at least yearly and whenever the facility had a reportable allegation. She stated all types of abuse should be reported immediately. She revealed all allegations of abuse should be reported to the Director of Nursing (DON), Administrator, Ombudsman, and the police. During an interview on 09/15/2022 at 12:02 PM, Social Services (SS) Employee #1 revealed she no longer worked at the facility. She indicated Resident #176 came to her and stated he/she was missing $110.00 from a wallet, then changed his/her story to missing money missing from his/her bank account. She revealed Resident #176 did not have a trust account or any money held by the facility. With Resident #176's permission, SS #1 reached out to the resident's bank and got his/her bank statements, which showed no withdrawals. SS #1 indicated she reached out to Emergency Contact #1, who stated she brought a wallet with $60.00 to the facility after the resident was admitted. According to SS #1, the emergency contact denied having given Resident #176 a wallet with $110.00. SS #1 stated Resident #176 gave Friend #1 his/her personal debit card and cash to buy things and that she had educated Resident #176 many times in the past about giving Friend #1 money, but he/she did not want to hear that and got offended easily. SS #1 indicated that after the allegation, Resident #176 admitted he/she gave $20.00 to Friend #1, then spent $35.00 for a notary. She stated Resident #176 provided a statement on 06/15/2022, in which the resident admitted the	4 131		

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4 131	Continued From page 5	4 131		

money was not stolen or misplaced. She revealed the allegation made by Resident #176 was of missing property, but the resident did not want the police called, and that was why the allegation was not reported to the police.

Review of a handwritten statement, dated 06/15/2022 and signed by Resident #176 and SS #1, revealed the resident denied having had money stolen from him/her, "I did not have money stolen or misplaced. I gave money to [Friend #1] to buy things for me." The resident's allegation was made 13 days prior to the date of this statement and was not reported to local law enforcement during that timeframe.

During an interview on 09/15/2022 at 3:36 PM, the Administrator/Abuse Coordinator revealed Resident #176 notified SS #1 he/she was missing $110.00 from a wallet at first, then stated the money was missing from an account. The Administrator indicated he submitted a report to the state agency and notified the physician, responsible party, and APS. The Administrator indicated Resident #176 admitted on 06/15/2022 per a signed statement that the money was not stolen or misplaced but was given to Friend #1. The Administrator further revealed he did not report the allegation to the police because Resident #176's story changed several times. The Administrator indicated he would have reported the allegation if Resident #176 was more alert and oriented, but Resident #176 had no inventory of the items and the story changed two or three times. He revealed if a resident's allegation involved abuse, then the police were notified.

During an interview on 09/15/2022 at 3:57 PM, the Director of Nursing (DON) revealed that

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4 131	Continued From page 6 Resident #176 reported the allegation to SS #1, who was no longer employed by the facility. She stated her involvement with this investigation were limited. The DON indicated when a resident reported abuse, the alleged perpetrator would be removed from the facility if it was a staff member, ensure the safety of the victim, immediately start an investigation which included interviews and record review, then notify the doctor, family, APS, the state agency, and the police. The DON stated Resident #176 did not want the police called, so that was why the allegation was not reported to them. During a follow-up interview on 09/16/2022 at 10:56 AM, the DON revealed Resident #176's allegation was an allegation of abuse and should have been reported to the police. She stated going forward, the police would be called for allegations of abuse, including misappropriation / exploitation. During an interview on 09/16/2022 at 11:00 AM, the Administrator revealed he was aware of the facility policy that all allegations of abuse must be reported to all the proper authorities. He revealed Resident #176's allegation was a type of abuse. The Administrator revealed his expectations were to effectively stop abuse from occurring, mitigate when it happened, protect the resident from any forms of abuse, and report the allegations.	4 131		