STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED 125010 B. WING		-	AND HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
MAIL OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE_2P: CODE LEAH HOSPITAL STREET ADDRESS. CITY, STATE_2P: CODE Image: Comparison of the context of the conte	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		(X3) DATE SURVEY
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LEARINGSPTIAL DONCLULU, HI SéRIE (***) TR0 ISAUMARY STATEMENT OF DEFICIENCIES ISAU DEFICIENCY WAIST DE PRECEDENT IN ULL REGULATORY OF LISE DEMINIPANE MYCHAUST DE PRECEDENT IN ULL REGULATORY OF LISE DEMINIPANE MYCHAUST DE REGULATORY OF LISE DEMINIPANE MYCHAUST DE REGULATORY OF LISE DEMINIPANE MYCHAUST DE REGULATORY OF LISE DEMINIPANE MYCHAUST DE REGULATORY OF LISE DEMINIPANE MYCHAUST DE REGULATORY OF LISE DEMINIPANE MYCHAUST DE REGULATORY OF LISE DEMINIPANE MYCHAUST DE REGULATORY OF LISE DE REGULATORY OF REGULATORY OF LISE DE REGULATORY OF LISE DE REGULATORY OF REGULATORY OF LISE DE REGULATORY OF REGULATORY OF LISE DE REGULATORY OF LISE DE REGULATORY OF REGULATORY OF REGULATORY OF LISE DE REGULATORY OF REGULATORY OF REGULATORY OF REGULATORY REGULATORY OF REGULATORY OF REGULATORY OF REGULATORY REGULATORY OF REGULATORY REGULATORY OF REGULATORY OF REGULATORY REGULATORY OF REGULATORY OF REGULATORY REGULATORY OF REGULATORY OF REGULATORY REGULATORY OF REGULATORY REGULATORY OF REGULATORY REGULATORY OF REGULATORY OF REGULATORY REGULATORY OF REGULATORY REGULATORY OF REGULATORY REGULATORY OF REGULATORY REGULATORY OF REGULATORY REGULATORY OF REGULATORY REGULATORY REGULATORY REGULATORY REGULATORY REGULATORY REGULATORY REGULATORY REGULA	NAME OF P	ROVIDER OR SUPPLIER				
might Txc IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PREIN Txc IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY commuting Constraints F 000 INITIAL COMMENTS F 000 F 000 A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 09/11/23 - 09/14/23. The facility was not in compliance with 2/CFR 483 Subpart B. Facility Reported Incidents (ACTS #10019, 10418, 1043/43) were also investigated. There was non-compliance in ACTS 10434. F 584 F 584 Survey Census: 104 Sample Size: 29 Safe(Clean/Comfortable/Homelike Environment The resident has a right to a safe, clean, confortable and homelike environment. The resident has a right to a safe, clean, confortable and homelike environment. The resident has a right to a safe, clean, confortable and nomelike environment. The resident has a right to e safe(). F 584 The facility must provide- §483.100(/1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. In the facility must provide- §483.100(/2) Housekeeping and maintenance services necessary to maintain a sanitazy, orderly, and comfortable interior; §483.100(/3) Clean bed and bath linens that are Inter Material	LEAHI HC	SPITAL				
A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 09/11/23 - 09/14/23. The facility was not in compliance with 42 CFR 483 Subpart B. Facility Reported Incidents (ACTS #10019, 10418, 10434) were also investigated. There was non-compliance in ACTS 10434. Survey Census: 104 Sample Size: 29 F 584 Sref(S): 483.10(i)(-(7) § 483.10(i) Safe Environment. The resident has a right to a safe, clean, confortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical ayout of the facility maximizes resident independence and does not pose a safely risk. (i) The facility all exercise resonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance syrices necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA	E COMPLETION
Office of Health Care Assurance (OHCA) on 09/11/23 · 09/14/23. The facility was not in compliance with 42 CFR 443 Subpart B. Facility Reported Incidents (ACTS #10019, 10418, 10434) were also investigated. Three was non-compliance in ACTS 10434. Survey Census: 104 Sample Size: 29 Sample Size: 29 CFR(s): 483.10(i)(1)-(7) §483.10(i)(1) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) Asafe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or thet. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 000	INITIAL COMMEN	TS	F 000		
F 584 SS=D Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) F 584 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. F 584 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. F 584 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. F 584 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. § 483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; § 483.10(i)(3) Clean bed and bath linens that are THE X8)DATE		Office of Health Ca 09/11/23 - 09/14/2 compliance with 42 Reported Incidents 10434) were also i non-compliance in Survey Census: 1	are Assurance (OHCA) on 3. The facility was not in 2 CFR 483 Subpart B. Facility 5 (ACTS #10019, 10418, nvestigated. There was ACTS 10434.			
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Image: Comparison of the clean of the		Safe/Clean/Comfo		F 584		
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are TITLE (X8) DATE		The resident has a comfortable and he but not limited to re	right to a safe, clean, omelike environment, including eceiving treatment and			
services necessary to maintain a sanitary, orderly, and comfortable interior; \$483.10(i)(3) Clean bed and bath linens that are Image: Comparison of the service of the ser		 §483.10(i)(1) A sather the service of the	e, clean, comfortable, and eent, allowing the resident to onal belongings to the extent esuring that the resident can ervices safely and that the he facility maximizes resident does not pose a safety risk. I exercise reasonable care for			
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		services necessary	/ to maintain a sanitary, orderly,			
		§483.10(i)(3) Clear	n bed and bath linens that are			
			ER/SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE	(X6) DATE

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.

STATE MENU OF DEFICIENCIES AND ELAN OF CORRECTION (X1) DATE SURVEY DENUTIFICATION NUMBER (X2) MULTIFIE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETE A BUILDING NAME OF FROVUDER OR SUPPLIER 125010 B. MING 3176E1 ADDRESS, CITY, SIATE JPL CODE 3675 SUADEA VENUE HONOLULU, HI SESI6 09/14/202 LEAHI HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES IFAC DEFICIENCIES (CALID MEEDICATION FOR CONFECTION RESULTATION FOR CONFECTION RESULTATION RESULT		-	ND HUMAN SERVICES MEDICAID SERVICES				FORM): 09/29/2023 MAPPROVED). 0938-0391
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375 KILAUEA AVENUE HONOLULU, HI Setti HONOLULU, HI Setti HONOLULU, HI Setti RECULTORY OR LSC DENTRYING INFORMATION) PREEX TVG SUMMARY STATEMENT OF DEFICIENCIES (EACH DERICENCY ACTION SHOULD DE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Down (EACH DERICENCE ACTION SHOULD DE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OWN DEFICIENCY F 584 Continued From page 1 in good condition; F 584 F 584 \$483.10(i)(4) Private closet space in each resident room, as specified in \$483.90 (e)(2)(iv); F 584 \$483.10(i)(5) Adequate and comfortable lighting levels in all areas; F 584 \$483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and \$483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: D; Based on observation and interview, the facility failed to assure a safe, clean, and comfortable homelike environment for two of five sampled residents (Resident (R)37, and R43). Findings include: On initial tour of facility 09/11/23 at 09:56 AM, at the bedside of FA3's, equipment was observed. Surveyor noted that the tube feeding pole and parts of the bed with spiled/spots of questionable formula and a dife crusty substance was spiled An observation on 09/11/23 at 12:18 PM, tube feeding was in progress for R 37. Noted fresh formula and a dife crusty substance was spiled			125010	B. WING _			09/	14/202 <u>3</u>
LEAHI HOSPITAL HONOLULU, HI 98816 (M) ID PHEEK TAG SUMMARY STATEMENT OF DEFICIENCIES (EAAH DEFICIENCY MUST BERCEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDENT ACTION SIGUED B (EAAH DEFICIENCY MUST BERCEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) PROVIDENT TAG PROVIDENT ACTION SIGUED B (EAAH DEFICIENCY MUST BERCEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) PROVIDENT TAG PROVIDENT ACTION SIGUED B (EAAH DEFICIENCY) Continued From page 1 in good condition: F 584 \$483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; F 584 F 584 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and S 483.10(i)(7) For the maintenance of comfortable sound levels. S This RECURRENT is not met as evidenced by: Based on observation and interview, the facility failed to assure asfe, clean, and comfortable homelike environment for two of five sampled residents (Resident (R)37, and R43). Findings include: On initial tour of facility 09/11/23 at 09:56 AM, at the bedside of R43's, equipment was observed. Surveyor noted that the tube feeding pole and parts of the bed with black stain and/or questionable (dirt. An observation on 09/11/23 at 12:18 PM, tube feeding was in progress for R 37. Noted fresh formula and a dried crusty subtance was spilled	NAME OF P	ROVIDER OR SUPPLIER						
Precipy TXG (EACH DEFICIENCY MIG INFORMATION) PRETX TXG (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCE OF THE APPROPRIATE COMPL CROSS-REFERENCE OF THE APPROPRIATE F 584 Continued From page 1 in good condition; F 584 F 584 § 483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); F 584 § 483.10(i)(5) Adequate and comfortable lighting levels in all areas; F 584 § 483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and F 584 § 483.10(i)(7) For the maintenance of comfortable sound levels. This RECURRENT is not met as evidenced by: b; Based on observation and interview, the facility failed to assure asfe, clean, and comfortable homelike environment for two of five sampled residents (Resident (R)37, and R43). Findings include: On initial tour of facility 09/11/23 at 09:56 AM, at the bedside of R43's, equipment was observed. Surveyor noted that the tube feeding pole and parts of the bed with paleck stain and/or questionable dirt. An observation on 09/11/23 at 12:18 PM, tube feeding was in progress for R 37. Noted fresh formula and a dired crusty substance was spilled	LEAHI HO	SPITAL						
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feeding was in progress for R 37. Noted fresh formula and a dried crusty substance was spilled		the bedside of R43's Surveyor noted that parts of the bed were of questionable form Also noted were area	, equipment was observed. the tube feeding pole and e splattered with spilled/spots ula which smelled like milk. as of the bed with black stain					
On 09/12/23 at 08:44 AM, surveyor observed		feeding was in progra formula and a dried o on the pole where th	ess for R 37. Noted fresh crusty substance was spilled e formula bag hangs.					

If continuation sheet Page 2 of 23

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES		r.	FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		0	MB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
AND I LAN OI	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING		
		125010	B. WING		00/44/0000
NAME OF P	ROVIDER OR SUPPLIER	120010		STREET ADDRESS, CITY, STATE, ZIP CODE	09/14/202 <u>3</u>
				3675 KILAUEA AVENUE	
LEAHI HO	SPITAL			HONOLULU, HI 96816	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	bed were splattered of substance. Noted an formula. On 09/13/23 at 09:44 nursing supervisor (N and NS1concurrently equipment and the su that cleaning is need	feeding machine, pole, and with a milky and crusty n odor that smelled like I AM, an interview with NS)1 was done. Surveyor	F 584		
F 609 SS=E			F 609		
	involving abuse, neg mistreatment, includi source and misappro are reported immedia hours after the allega that cause the allega serious bodily injury, the events that cause abuse and do not res the administrator of t officials (including to adult protective servi for jurisdiction in long accordance with Stat procedures. §483.12(c)(4) Report investigations to the	ng injuries of unknown opriation of resident property, ately, but not later than 2 ation is made, if the events tion involve abuse or result in or not later than 24 hours if e the allegation do not involve sult in serious bodily injury, to he facility and to other the State Survey Agency and ces where state law provides g-term care facilities) in te law through established			

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED MB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		X3) DATE SURVEY COMPLETED
		125010	B. WING		09/14/2023
NAME OF P	ROVIDER OR SUPPLIER		S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	
LEAHI HO	CDITAL		30	675 KILAUEA AVENUE	
	SFIIAL		н	ONOLULU, HI 96816	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 609	Survey Agency, withi incident, and if the all appropriate corrective This REQUIREMENT by: Based on interviews facility failed to ensur an injury of unknown bodily harm, were rep later than 2 hours afte to the administrator of officials, including to (SA) and Adult Protect residents (Resident (a result of this deficie at a risk of harm, incl Findings include: The facility's Policy, F Abuse, Neglect, Invo Misappropriation of F 11/03/21 was reviewe not be humiliated, ha policy to report allege violations involving all seclusion, injury of ur misappropriation of p Administrator and the shall be reported to th specified timelines. (Cross Reference to Investigate/Prevent/C 1) Review of the Sta Complaints/Incidents	te law, including to the State n 5 working days of the leged violation is verified e action must be taken. Γ is not met as evidenced and record reviews, the re alleged verbal abuse and source resulting in serious ported immediately, but not er the allegation was made of the facility and other the State Survey Agency ctive Services (APS) for two R)82 and R31) sampled. As ent practice, all residents are uding psychosocial harm.	F 609		

Facility ID: HI02LTC5010

If continuation sheet Page 4 of 23

DEPART	MENT OF HEALTH A	ND HUMAN SERVICES				APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE S COMPL	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	G		
		125010	B. WING			
		125010	D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	09/1	14/202 <u>3</u>
NAME OF PI	ROVIDER OR SUPPLIER			3675 KILAUEA AVENUE		
LEAHI HO	SPITAL			HONOLULU, HI 96816		
						()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
PREFIX	Continued From pag emailed an Event Re abuse injury of unkno 07/16/23 at 03:32 AM documented on 07/1 Nurse Aide (CNA)1 r (LN)56 that R82 was to the lower left abdo assessment, NS56 d bed guarding the left included an interpret telephone to commu nurse instructed the resident where does answered, "The lady resident was asked a sore? R82 answered The resident refused head to toe physical redness, no swelling (discoloration of the under the skin, typica physician was notifie left lower rib cage. On 09/13/23 at 2:58 record review of R82 (EHR) to include the investigation of the a interview with the Dir Review of R82's x-ra sustained acute later the physician interpre- signed the results on staff wrote " Noted 0 by staff acknowledgir results. During the in	e 4 eport of an allegation of own origin to the SA on <i>M</i> . The initial Event Report 5/23 at 03:05 PM, a Certified eported to Licensed Nurse displaying symptoms of pain ominal area. Upon locumented R82 was lying in side. LN56 called and er language service via nicate with the resident. The interpreter to ask the it sore? The resident initially with pain went away". The a second time, where does it d, "Someone kicked her". I to go to the hospital, LN56's assessment documented no , and no ecchymosis skin resulting in bleeding ally caused by bruising). The d and ordered an x-ray of the PM, conducted a concurrent C's electronic health record facility's completed llegation of abuse and rector of Nursing (DON). by results documented R82 ral 7th and 8th rib fractures, eting the x-ray findings 07/15/23" which was initialed ng receipt of the x-ray terview, the DON stated she		CROSS-REFERENCED TO THE AF DEFICIENCY)		
	was not notified by N the incident within 2	lursing Supervisor (NS)29 of hours of the incident but ovide documentation of the				

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	-	ND HUMAN SERVICES			FORM APPROVED
STATEMENT	IN THE MEDICARE & OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		125010	B. WING	ETN/	09/14/2023
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	
LEAHI HO	OSPITAL			5 KILAUEA AVENUE	
			но	NOLULU, HI 96816	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 609	exact time. The DON no documentation of was notified of the in there a delay in NS2 and the DON. DON the incident as an all staff know the resided did not believe that s The DON confirmed an initial determination not credible prior to r have been treated as and/or injury of unkn was not reported to S and confirmed the fai incident to APS as re- regulation. On 09/13/23 at 04:38 with the Administrator Administrator first be allegation of abuse. the investigation and confirmed she was n incident, but once shi informed nursing sta incident is a reportat APS should be notifi investigation should Administrator confirm immediately notify th soon as the resident physical abuse but d On 09/14/23 at 02:50 with NS29 regarding NS29 confirmed the deficits and her asset	A also confirmed there was if the time the Administrator acident. Inquired why was 9 informing the Administrator stated, NS29 did not identify legation of abuse because ent has cognitive deficits and someone kicked the resident. NS29, and the DON made on that R82's allegation was reporting the allegation and of s an allegation of abuse own origin. Thus, the event SA with in the 2-hour period acility did not report the equired by federal and state 8 PM, conducted an interview or. Inquired when did the ecome aware of R82's The Administrator reviewed 4 phone records and not immediately notified of the ne became aware, she ff and the DON that R82's oble event, and the SA and ed, and a complete be conducted. The ned NS29 did not ne DON and Administrator as a verbalized the allegation of	F 609		

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		125010	B. WING		09/14/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LEAHI HO	SPITAL			3675 KILAUEA AVENUE	
				HONOLULU, HI 96816	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 609	Continued From pag	e 6	F 6	609	
	of abuse. NS29 coul	onstitute as a credible report d not recall or provide en she notified the DON and he event.			
	interview with R31 at stated, "Last week a really mean to him an CNA23 called the res "treated me like a du that he was upset be roommate, who is to roughly and he did no had reported the inci- the facility knows abo CNA23 continued to the resident. R31 rep	8:58 AM, conducted an the resident's bedside. R31 male CNA (CNA23) was nd his roommates." and sident a "motherfucker" and mmy." R31 also reported cause CNA23 handled his rally dependent on staff, ot like that. Inquired if R31 dent to staff. R31 confirmed but the incident and that work on the same floor as ported feeling extremely t of CNA23 and in addition to ent.			
	interview with Nurse about the incident R3 NM confirmed she be on Monday, 09/11/23 incident as R31 havin CNA23. NM5 stated called him the name have teeth or hair, wi	view of R31's EHR and Manager (NM)5. Inquired B1 reported to this surveyor. ecame aware of the situation 5. LN56 documented the ng a behavior of swearing at R31 reported that CNA23 of an actor that does not nich upset R31. R31 felt like nim. NM5 stated LN56 ress the situation.			
	concurrent record rev DON regarding R31's DON reviewed the fa	view and interview with the s allegation of abuse. The cility's documentation and nformed of the incident on			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 09/29/20 FORM APPROVE OMB NO: 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		125010	B. WING		09/14/202 <u>3</u>
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
LEAHI HO	SPITAL		367	5 KILAUEA AVENUE	
22/ 11/ 110	0111/12		НО	NOLULU, HI 96816	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 609	Continued From pa	age 7	F 609		
1 000	-	-	F 009		
		event report was created and d not identify R31's reports of			
		s an allegation of abuse. The			
	DON confirmed NS				
		her the allegation is credible			
		e allegation. As a result of			
		ination that the allegation of			
	abuse was not cree	dible, the DON and			
		not immediately made aware			
		IA23 should have been sent			
		e resident and/or other resident			
	•	of abuse, and the SA and APS			
	timeframe but was	notified within the 2-hour			
		not.			
	On 09/14/23 at 12:	33 PM, conducted a			
		eview and interview with			
	Social Worker (SW)1 regarding R31's reported			
		ed on 09/08/23, SW1 heard a			
		allway involving R31. SW1			
		olarium to calm the resident			
		what was going on. SW1			
		ad not seen R31 this mad			
	-	ormed SW1 that CNA23 told nam, which means fuck you in			
		he solarium with R31, SW1			
		ame into the room and began			
	· ·	bout what happened, then			
		f. SW1 stated she was			
		NA23's behavior and			
		resident. SW1 stated that she			
		INS29 that the incident			
		nd R31 was possibly abuse,			
		not be working on the floor			
		n is completed, and the DON			
		tor should be notified			
	-	reported that CNA23 informed			
		ed to go home and did not ne allegations of abuse, but			
		ie allegations of abuse, but			

Facility ID: HI02LTC5010

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	-	ND HUMAN SERVICES			FORM	M APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
NAME OF P	ROVIDER OR SUPPLIER	125010	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	(14/202 <u>3</u>
LEAHI HO	SPITAL			3675 KILAUEA AVENUE HONOLULU, HI 96816		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 609 F 610 SS=E	would be fired for results was reassigned to an and worked the rest of the res	23 that if he went home, he sident abandonment. CNA23 nother part on the same floor of the shift. PM, conducted an interview R31's allegation of verbal quired if NS29 identified the tion of verbal abuse. NS29 entify the incident involving allegation of abuse because nown will harass staff. NS29 d informed her that the tially be abuse and needed to g to the the facility's policy buse. NS29 stated she ance, informed CNA23 he did not inform the DON of the incident. NS29 nt should have been handled buse but did not. Correct Alleged Violation (-(4)) ase to allegations of abuse, or mistreatment, the facility evidence that all alleged ghly investigated. In further potential abuse, or mistreatment while the bogress.	F 60			

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		ND HUMAN SERVICES			PRINTED: 09/29/2023 FORM APPROVED
	S FOR MEDICARE &	X MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		125010	B. WING		00/44/0000
NAME OF P	ROVIDER OR SUPPLIER	120010		TREET ADDRESS, CITY, STATE, ZIP CODE	09/14/202 <u>3</u>
				675 KILAUEA AVENUE	
LEAHI HO	SPITAL		- F	IONOLULU, HI 96816	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· · ·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/	DATE
TAG	REGULATORT OF	(LSC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	NE .
			1		
F 610	Continued From page	ge 9	F 610		
	accordance with Sta	ate law, including to the State			
		nin 5 working days of the			
	incident, and if the a	alleged violation is verified			
		ve action must be taken.			
		IT is not met as evidenced			
	by:				
		ions and interviews, in gation of abuse the facility			
		gations of abuse were			
		ited, prevent further abuse			
		on was in progress. As a			
		nt practice, residents are at			
	risk of abuse and ex	-			
	Findings include:				
	(Cross Reference to Violations)	o F609: Reporting of Alleged			
	On 09/13/23 at 02:5	8 PM. conducted a			
		eview of R82's electronic			
	health record (EHR)) of the facility's completed			
		allegation of abuse with the			
	-	(DON). Inquired with the DON			
		the investigation related to			
	R82's report that so	ed Nursing Staff (LN)56			
		ent's lower left abdomen for			
	u	firmed as a result of Nursing			
		determination that R82's			
		ticked in response to			
	questioning regardir	ng lower left abdomen pain as			
		allegation, the incident was			
		stigated, but should have			
		R82's physician determined			
		actured ribs was a result of			
	-	from being kicked. Inquired			
		diagnosis of Osteopenia at on was made. The DON			

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	-	AND HUMAN SERVICES			FORM APPROVED DMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
NAME OF P	ROVIDER OR SUPPLIER	125010	B. WINGS	TREET ADDRESS, CITY, STATE, ZIP CODE	09/14/202 <u>3</u>
LEAHI HO	SPITAL			675 KILAUEA AVENUE IONOLULU, HI 96816	_
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 610	Osteopenia or sign allegation of abuse Aide (CNA)1 identifi the lower left abdor lying in bed (the res side by side which resident's safety) a resident there was Inquired about the DON confirmed tha have cognitive defin make needs known been able to discer the injury. Reviewe and inquired about resident had signs assisting CNA1 with the shower, prior to bed. The DON cor CNA34's statement resident's activities in the bed. Inquired not interviewed the completed witness notes as the source investigation. After investigation had m possible that R82 of fractured ribs during which were not inve discrediting the res conducting a thorout the facility's policy a an allegation of abut the procedure for in	Ige 10 not have a diagnosis of /symptoms prior to the . DON stated Certified Nurse fied R82's symptoms of pain in men when the resident was sident has three mattresses are placed on the floor for the nd when LN56 assessed the no observable trauma. resident's cognition and the t although the resident does cits the resident is able to a t the resident may have n if a person was the cause of ed staff 's written statements CNA34's statement that the and symptoms of pain while h transferring the resident from o returning the resident to her firmed she was not aware that t and did not investigate the prior to LN56 assessing R82 if the DON confirmed she had staff involved and used the statements and progress e of information for the reassessing the details of the ON confirmed a thorough ot been conducted and it is ould have sustained the g transfer or other means estigated due to staff ident's allegation before up investigation. Reviewed and procedure for investigating use and the DON confirmed the DON confirmed and procedure for investigating use and the DON confirmed to been.	F 610		

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		ND HUMAN SERVICES			PRINTED: 09/29/202 FORM APPROVEI OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF P	ROVIDER OR SUPPLIER	125010		EET ADDRESS, CITY, STATE, ZIP CODE	09/14/202 <u>3</u>
LEAHI HC	SPITAL			KILAUEA AVENUE IOLULU, HI 96816	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 610	On 09/14/23 at 02:5 with NS29 regarding NS29 confirmed the deficits and her asso what the resident wa her opinion, did not of abuse. Notice Requirement CFR(s): 483.15(c)(3) §483.15(c)(3) Notice Before a facility tran resident, the facility (i) Notify the residen representative(s) of the reasons for the language and mann facility must send a representative of the Long-Term Care On (ii) Record the reaso discharge in the res accordance with par and (iii) Include in the no paragraph (c)(5) of the §483.15(c)(4) Timin (i) Except as specific (c)(8) of this section discharge required to made by the facility resident is transferre (ii) Notice must be no before transfer or di (A) The safety of inc	0 PM, conducted an interview g R82's allegation of abuse. resident has cognitive essment of the resident and as saying to the interpreter, in constitute as a credible report as Before Transfer/Discharge b)-(6)(8) e before transfer. sfers or discharges a must- at and the resident's the transfer or discharge and move in writing and in a er they understand. The copy of the notice to a e Office of the State hbudsman. ons for the transfer or ident's medical record in ragraph (c)(2) of this section; btice the items described in this section. g of the notice. ed in paragraphs (c)(4)(ii) and , the notice of transfer or under this section must be at least 30 days before the ed or discharged. nade as soon as practicable	F 610		

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		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 09/29/202 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PI	ROVIDER OR SUPPLIER	125010	367	EET ADDRESS, CITY, STATE, ZIP CODE 5 KILAUEA AVENUE NOLULU, HI 96816	09/14/202 <u>3</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 623	be endangered, unit this section; (C) The resident's h allow a more immed under paragraph (c (D) An immediate the required by the resident under paragraph (c (E) A resident has n days. §483.15(c)(5) Content notice specified in p must include the fol (i) The reason for t (ii) The effective da (iii) The location to transferred or disch (iv) A statement of t including the name, and telephone nume receives such reque to obtain an appeal completing the form hearing request; (v) The name, addr telephone number of Long-Term Care Or (vi) For nursing faci and developmental disabilities, the mai telephone number of the protection and a developmental disa C of the Developme and Bill of Rights A	dividuals in the facility would der paragraph (c)(1)(i)(D) of mealth improves sufficiently to diate transfer or discharge,)(1)(i)(B) of this section; ransfer or discharge is dent's urgent medical needs,)(1)(i)(A) of this section; or not resided in the facility for 30 ents of the notice. The written baragraph (c)(3) of this section llowing: ransfer or discharge; te of transfer or discharge; which the resident is harged; the resident's appeal rights, , address (mailing and email), ber of the entity which ests; and information on how form and assistance in n and submitting the appeal ess (mailing and email) and of the Office of the State	F 623		

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		125010	B. WING		09/14/202 <u>3</u>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LEAHI HO	CDITAL			3675 KILAUEA AVENUE	
	SFIIAL			HONOLULU, HI 96816	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 623	disorder or related di email address and te agency responsible f advocacy of individua established under the for Mentally III Individual stablished under the for Mentally III Individual §483.15(c)(6) Chang If the information in the effecting the transfer must update the reci- as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification pr to the State Survey A State Long-Term Car the facility, and the re- well as the plan for the relocation of the reside 483.70(I). This REQUIREMENT by: Based on record rev- review of policy, the written notice of disci (R)R32 & R90) out of a result of this deficient for miscommunication of discharge. Findings include: 1) Review of the Elect	ty residents with a mental sabilities, the mailing and elephone number of the for the protection and als with a mental disorder e Protection and Advocacy luals Act.	F 6.	523	

Facility ID: HI02LTC5010

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		ND HUMAN SERVICES			PRINTED: 09/2 FORM APPI	ROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
NAME OF P	NAME OF PROVIDER OR SUPPLIER		B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	09/14/20	2 <u>3</u>
				75 KILAUEA AVENUE		
LEAHI HC	SPITAL		н	DNOLULU, HI 96816		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMF	(X5) PLETION DATE
F 623	Diabetes, High Blood from the hospital on not show any written resident and/or represent During staff interview Social Worker (SW1 facility did not provid discharge to R32 and Discharge/Transfer N the family, represent phone of discharge to notification given. 2) On 09/12/23 at 10 of R90's EHR docum transferred to the ho potential of sepsis re and increased fever. Notice form was not EHR. During staff interview SW1 acknowledged provide written notific and/or representative Review of facility pol Requirements and D to ensure transfer an are met and docume as well as written no and resident's family representative for tra facility. Policy; Resid discharged from the reasons: The transfer	gnosis including Stroke, d Pressure and discharged 07/03/23. Further review did notice of discharge to the esentative. (on 09/13/23 at 01:50 PM,) acknowledged that the e written notification of d/or representative. The Notice form for R32 showed ative was verbally notified by but there was no written (19 AM, conducted a review hented the resident was spital on 05/26/23 due to the dated to unstable vital signs The Discharge/Transfer documented in the resident's (on 09/13/23 at 01:50 PM, that the facility did not cation of discharge to R90 e. (or titled Transfer/Discharge to cumentation read Purpose; and discharge requirements inted in the medical record, tice provided to the resident	F 623			

Facility ID: HI02LTC5010

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV. COMPLETE AND PLAN OF CORRECTION 125010 A. BUILDING (X3) DATE SURV. COMPLETE NAME OF PROVIDER OR SUPPLIER 125010 B. WING 09/14/2 LEAHI HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		TH AND HUMAN SERVICES			PRINTED: 09/29/2023 FORM APPROVED OMB NO. 0938-0391	
Image: Name of provider or supplier Image: Name of provider or supplier Image: Name of provider or supplier LEAHI HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE Image: Name of provider or supplier 3675 KILAUEA AVENUE HONOLULU, HI 96816 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		(X3) DATE SURVEY COMPLETED	
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 COM	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	09/14/202 <u>3</u>	
HONOLULU, HI 96816 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COM						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COM	LEAHI HOSPITAL		н	ONOLULU, HI 96816		
	PREFIX (EACH DEFICI	ICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	DATE	
F 623 Continued From page 15 F 623 cannot be met in the facility A written notice will be given to the resident, resident's regionsible party, and/or resident's legal representative at least 30 days or as soon as practicable prior to, or upon, transfer or discharge of the resident. The notice multiple is a soon as practicable prior to, or upon, transfer or discharge, inclusion on how to notify the the resident, and will include the reason for transfer/discharge, location to which the resident was transferred/discharge, location to which the resident and information on how to notify the Ombudsman and appropriate protection and advocacy agencies F 732 F 732 DSated Nurse Staffing Information F 732 SS=D CFR(s): 483.35(g)(1)-(4) F 732 Substity Data requirements. The facility must post the following information on a daily basis: (i) The current date. (iii) The current date. (iii) The current date. (iii) The current date. (iii) The current date. (i) The current date. (i) The current date. (i) The current date. (i) The current date. (ii) The facility muses of licensed and unlicensed nursing staff directly responsible for resident cares (as defined under State law). (c) Certified nurses can be result. (i) The facility must post the following information on a daily basis at the beginning of each shift. (i) Data must be posted a Stollowing information on a daily basis at the beginning of each shift. (i) Data must be posted a Stollowin	cannot be met in i will be given to the responsible party, representative at practicable prior to of the resident. T and manner unde will include the re- effective date of to which the residen right of appeal, ar the Ombudsman advocacy agencie Posted Nurse Sta SS=D CFR(s): 483.35(g) §483.35(g) Nurse §483.35(g)(1) Dat must post the follo basis: (i) Facility name. (ii) The current da (iii) The total num by the following c unlicensed nursin resident care per (A) Registered nu (B) Licensed prace vocational nurses (C) Certified nurses (C) Certified nurses (iv) Resident cens §483.35(g)(2) Pos (i) The facility must specified in parag daily basis at the (ii) Data must be	n the facility A written notice the resident, resident's ty, and/or resident's legal at least 30 days or as soon as r to, or upon, transfer or discharge The notice must be in a language derstandable to the resident, and reason for transfer/discharge, the f transfer or discharge, location to ent was transferred/discharged, and information on how to notify n and appropriate protection and cies taffing Information (g)(1)-(4) se Staffing Information. Deata requirements. The facility ollowing information on a daily e. date. mber and the actual hours worked categories of licensed and sing staff directly responsible for er shift: nurses. actical nurses or licensed es (as defined under State law). rse aides. nsus. Posting requirements. ust post the nurse staffing data agraph (g)(1) of this section on a e beginning of each shift. e posted as follows:				

Facility ID: HI02LTC5010

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DEPARTI	MENT OF HEALTH A	ND HUMAN SERVICES				MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	CONTRACTION		A. BUILDING		I	
		125010	B. WING		09	/14/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1-1/202
LEAHI HO	SPITAL			3675 KILAUEA AVENUE		
				HONOLULU, HI 96816		_
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 732	Continued From pag	e 16	F 73	2		
	(B) In a prominent pl residents and visitors	ace readily accessible to s.				
	staffing data. The fa written request, mak available to the publi exceed the communi §483.35(g)(4) Facility requirements. The fa posted daily nurse st 18 months, or as req is greater. This REQUIREMENT by: Based on observation review of policy proc post staffing information floor Young, out of the As a result of this de	ic for review at a cost not to ity standard. y data retention acility must maintain the taffing data for a minimum of juired by State law, whichever T is not met as evidenced ons, staff interview and edure, the facility failed to tion for one Nursing Unit, 4th oree Nursing Units sampled. ficiency the facility failed to make nurse staffing data				
	Findings include:	of the 4th floor Young Nursing				
	Unit on 09/11/23 at 1 information form pos was not completed. show the total number					
	the Director of Nursin	v on 09/11/23 at 02:30PM, ng acknowledged that the vas not completed as d.				

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	-	ND HUMAN SERVICES			FORM APPROVED		
CENTER		MB NO. 0938-0391					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION (>	(X3) DATE SURVEY COMPLETED			
		A. BUILDING					
		125010	B. WING		09/14/2023		
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	00/14/2020		
				3675 KILAUEA AVENUE			
LEAHI HOSPITAL			HONOLULU, HI 96816				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 732	Continued From pag	e 17	F 732				
F 761 SS=D	Review of facility pro Procedure for Staff P Effective immediately complete the Daily S hours and post in the board). At the begin Charge Nurse for the the census and staffi needed on the Daily sheet will be changer submitted to the Nurs Office for record keep Label/Store Drugs ar CFR(s): 483.45(g)(h) §483.45(g) Labeling Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the face biologicals in locked	cedure on Revised losting read the following: /, units are required to taff Posting sheet by 0700 e designated area (white hing of each shift, the e on-coming shift will verify ng, and make changes as Staff Posting sheet. The d at 0700 hours daily and sing Supervisor/Nursing bing nd Biologicals (1)(2) of Drugs and Biologicals is used in the facility must be e with currently accepted es, and include the ry and cautionary	F 761				
	storage of controlled the Comprehensive I Control Act of 1976 a abuse, except when						

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		ND HUMAN SERVICES			FORM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
	125010 NAME OF PROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	09/14/202 <u>3</u>	
LEAHI HOSPITAL			HONOLULU, HI 96816			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 761	be readily detected. This REQUIREMEN by: Based on observati review of policy, the padlock that was att refrigerator door on Unit. As a result of t failed to properly sto medications. Findings include: During observation of Unit, on 09/11/23 at refrigerator was not padlock there to sec was not locked. The immediate vicinity, a padlock and have at the refrigerator. Staff interview on 09 3rd floor Head Nurse padlock should have secured. Head Nurse padlock should have secured the refri Review of policy on Policy; Medications properly, following m pharmacy recomme integrity and to supp administration. The accessible only to lite	nimal and a missing dose can T is not met as evidenced ons, staff interview and facility failed to secure a ached to the medication the 3rd floor Young Nursing this deficiency, the facility ore the refrigerated of the 3rd floor Young Nursing 11:20AM, the medication secured. There was a cure the door, but the padlock ere was no staff in the and anyone could remove the ccess to the medications in 0/11/23 at 11:45AM with the e acknowledged that the e been locked and always se then locked the padlock igerator. Storage of Medication read and biologicals are stored hanufacturers or provider indations, to maintain their oort safe effective drug medication supply shall be censed nursing personnel, l, or staff members lawfully ister medications	F 76			

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	-	AND HUMAN SERVICES			FORM APPROVED MB NO. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING		(3) DATE SURVEY COMPLETED	
NAME OF P	NAME OF PROVIDER OR SUPPLIER		B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	09/14/202 <u>3</u>
LEAHI HOSPITAL				675 KILAUEA AVENUE IONOLULU, HI 96816	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761 F 880 SS=D	pharmacy staff, an- administer medicat aides) are allowed Medication rooms, supplies should rer attended by person Medication storage regular basis as a check. As problem recommendations to be taken Infection Preventio CFR(s): 483.80(a)(1) §483.80 Infection (2) The facility must es infection prevention designed to provide comfortable enviro development and t diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the foll §483.80(a)(1) A sy reporting, investiga and communicable staff, volunteers, vi providing services arrangement based	ations, only licensed nurses, d those lawfully authorized to ions (such as medication access to medications carts. cabinets and medication main locked when not in use or as with authorized access conditions are monitored on a random quality assurance (QA) as are identified, are made for corrective action m & Control 1)(2)(4)(e)(f) Control stablish and maintain an n and control program e a safe, sanitary and ment and to help prevent the ransmission of communicable tions. n prevention and control stablish an infection prevention m (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following	F 761		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING			(X3) DATE	E SURVEY PLETED	
125010 NAME OF PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CI 3675 KILAUEA AVENUE			09	/14/202 <u>3</u>	
LEAHI HC			HONOL	LULU, HI 96816			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	§483.80(a)(2) Writ procedures for the but are not limited (i) A system of sum possible communic infections before th persons in the faci (ii) When and to wi communicable dise reported; (iii) Standard and t to be followed to p (iv)When and how resident; including (A) The type and c depending upon th involved, and (B) A requirement least restrictive po- circumstances. (v) The circumstant must prohibit empl disease or infected contact with resider contact will transm (vi)The hand hygie by staff involved in §483.80(a)(4) A sy identified under the corrective actions §483.80(e) Linens Personnel must ha	ten standards, policies, and program, which must include, to: veillance designed to identify cable diseases or ney can spread to other lity; hom possible incidents of ease or infections should be ransmission-based precautions revent spread of infections; isolation should be used for a but not limited to: luration of the isolation, ne infectious agent or organism that the isolation should be the ssible for the resident under the ces under which the facility oyees with a communicable d skin lesions from direct int he disease; and me procedures to be followed direct resident contact. extem for recording incidents e facility's IPCP and the taken by the facility.	F 88	0			

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DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES			FORM APPROVED
CENTER	OMB NO. 0938-0391				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	(X2) MULTIPLE CONSTRUCTION (X		
		A. BUILDING	G	COMPLETED	
		125010	B. WING		09/14/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/14/202 <u>3</u>
				3675 KILAUEA AVENUE	
LEAHI HO	SPITAL			HONOLULU, HI 96816	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG F 880	Continued From pag The facility will condu IPCP and update the This REQUIREMENT by: Based on observation review, the facility fail hygiene and follow in deficient practice play at risk for the develop communicable diseas Findings include: 1) Observation was of 07:54 AM on the first A Health Screener (H self-swab Covid testi After the first surveyor HS collected the test table. HS then remove them in the trash carr gloves without hand second surveyor with second surveyor finis collected the test swa HS then removed his trash can. HS proceet the table containing to minutes later HS wal station. 2) Observation was of 08:50 AM on the four Registered Nurse (R	e 21 act an annual review of its ir program, as necessary. Γ is not met as evidenced ons, interviews, and record led to perform proper hand ifection control protocol. This ces the residents and visitors oment and transmission of se and infections. conducted on 09/11/23 at -floor visitor check-in station. IS) was observed conducting ing on three state surveyors. or performed self-swabbing, swab and placed it on the ved his gloves and threw hygiene and assisted the a self-swabbing. Once the shed self-swabbing, HS ab and placed it on the table. a gloves and placed it in the eded to perform tasks near he test kits. A couple ked away from the testing conducted on 09/13/23 at th-floor hallway. A	F 88	DEFICIENCY)	ATE DATE
	administered medica R34. Following medic	07 with the same gloves and tion via gastrostomy tube to cation administration, RN1 tomy tube dressing and			

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-	TH AND HUMAN SERVICES			FORM APPROVED MB NO. 0938-0391	
	RE & MEDICAID SERVICES				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION (X:	3) DATE SURVEY COMPLETED	
		TA: DOILDING			
	125010	B. WING		09/14/2023	
NAME OF PROVIDER OR SUPPLIE	R	5	STREET ADDRESS, CITY, STATE, ZIP CODE	· · · · ·	
LEAHI HOSPITAL			3675 KILAUEA AVENUE		
		I	HONOLULU, HI 96816		
PREFIX (EACH DEFI	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
gloves at the sat room. A minute and donned new change. She ap on the gastrosto change was com medication adm changing her gloInterview was com Admin the fourth facility staff are si when performingInterview was com Infection Prevent Admin telephone should be perfor glove changes at performing differ A review of the f Hygiene," dated policy indicated, Rubbing or Antisi putting on and at gloves is not a si before adminisi performing sterility	ash. RN1 also removed her me time and walked out of the later, RN1 returned to the room v gloves to finish the dressing plied ointment and new dressing ony tube site. Once dressing inpleted, RN1 proceeded with inistration without removing and oves. onducted on 09/13/23 at 09:46 -floor hallway. RN1 stated that supposed to change their gloves g different tasks. onducted with the facility's intionist (IP) on 09/13/23 at 10:17 me. IP stated that facility staff rming hand hygiene in between and change gloves when rent tasks. facility policy titled, "Hand 02/03/23 was conducted. The "Indications for Antiseptic Hand septic Handwashingbefore fifter removing gloves (wearing substitute for hand hygiene) stering medicationsBefore le or clean procedures such as o urinary catheterizations, IV	F 880			

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