STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125002	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilo Benioff Medical Center	1190 Waianuenue Avenue Hilo, HI 96720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22063 Based on record review and interview, the facility failed to protect the residents' rights to be free from physical abuse by another resident. The facility did not assure residents with a history of distressed behaviors were identified to be at risk for abuse. The facility did not ensure staff were provided with training to assess potential situations that may result in abuse (Cross Reference to F943 - Abuse, Neglect, and Exploitation Training). The facility did not assure residents with a prior incident were supervised and monitored on the lanai. The facility submitted reports alleging resident-to-resident abuse involving a cognitive resident (Resident 44) that had two incidents as the alleged perpetrator, one with a cognitively impaired resident (Resident 33) and a cognitive resident (Resident 3). There were two incidents involving Resident (R)44 and R33. This deficient practice has the potential to result in psychosocial harm and/or injury. Findings include: 1) ACTS #HI00011229 On 09/26/24 at 12:30 PM, the facility submitted an Event Report regarding an allegation of resident-to-resident abuse involving R44 and R33. R44 was identified as the alleged perpetrator and R33 as the alleged victim. The facility reported on 09/26/24 at 10:45 AM, R44 was observed by staff to wheel out to the lanai and began throwing garden rocks at R33. This was witnessed by two Certified Nurse Aides (CNA) who were eating lunch on the lanai. The CNAs stopped R44 and separated them. R44 accused R33 of taking her papaya the day before. R33 was noted with a bruise to the left forearm. The residents were separated, and the activities staff calmed R44. R44 requested papaya which was immediately provided by dietary. Subsequently, R33 noted with bruise (1.5 cm x .4 cm) on left forearm. R33 was unable to recall the event. Interviews with the staff present found R44 ate alone on the lanai and R33 ate in the dayroom. R33 went out on the lanai after lunch. Staff did not witness R33 taking food from R44 and R33 does not have history of taking food from others. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residents reportedly were kept apart, and no verbalizations of aggression or anger noted during investigation. In service was provided to all staff on abuse and neglect with focus on resident-to-resident altercation. Facility deemed altercation was substantiated as there were witnesses present at the time. On the morning of 01/27/25 observed R44 was on droplet precautions for the flu. R44 was quarantined to her room. On 01/28/25 at 08:00 AM, attempted to interview R44 at breakfast. R44 was visited at bedside. She was eating hot cereal, introductions were made R44 did not acknowledge my presence. As her mouth was full with cereal, informed her I'd wait until she swallowed her cereal, she looked up, made eye contact and took another spoonful of cereal. Requested an interview, R44 did not respond. On 01/30/25 at 10:26 AM observed R44 sitting alone on the lanai. It was difficult to see her as she was sitting to the side and could not be seen from across the activity/dining room. Record review notes R44 was admitted to the facility on [DATE] from an acute hospital. Diagnoses include cerebrovascular accident, hemiplegia, and diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) with assessment reference date of 11/12/24 notes R44 is cognitively intact, scored a 15 on the Brief Interview for Mental Status (BIMS). A review of Section D. Mood, the mood interview was conducted, R44 noted with the presence of the following mood symptoms: little interest or pleasure in doing things; feeling down, depressed, or hopeless, trouble falling or staying asleep or sleeping too much; poor appetite; feeling bad about yourself or that you are a failure or have let yourself or family down; and moving or speaking so slowly that other people could have noticed. R44 was not coded for exhibiting behaviors during the assessment period. R44 was seen by the psychologist on 10/17/24. The psychologist notes R44 tends to become agitated, and hoards (mostly food). R44 reportedly not on psychotropic or have psychiatric history. The recommendation/plan is to continue standard behavioral oversight and interventions to provide resident time to settle into her new placement. Review of the care plan for behavioral symptoms noted the following interventions, I can be impatient and have history of changing my own briefs while in my bed/room, remind to use call light and educate me on the importance of being patient and the risks of changing my own brief. Following the incident, the care plan was revised (09/26/24) to include, please ensure that I am not seated near resident in E2 (R33) during meals, as I think she stole food from me which made me upset. R33 was admitted to the facility on [DATE], diagnoses include but not limited to vascular dementia with behavioral disturbance, acute subdural hematoma, and insomnia. A review of the quarterly MDS with ARD of 12/10/24 notes, R33 scored a three (severe cognitive impairment) upon application of the BIMS. R33 noted with no mood or behavioral symptoms. On 01/27/25 at 01:09 PM interviewed R33 in her room. R33 was unable to recall any incident(s) with fell ow residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R33's care plan for behavioral symptoms included intervention when out in the dayroom staff will have visual on me at all times until further notice. Although facility noted R33 does not have a history of taking food from other, the care plan was revised, 09/26/24 to include I may take food that is left on table unattended, please redirect me. 2) ACTS #HI00011356 On 12/08/24 at 02:41 PM, the facility submitted an Event Report regarding an allegation of resident-to-resident abuse. This is second event between R44 and R33 while on the lanai. R44 was identified as the alleged victim and R33 as the alleged perpetrator. Report indicates on 12/08/24 at 12:26 PM, R44 was sitting outside on the facility's lanai. Activities Aide (AA) saw R33 heading out to the lanai on her wheelchair. Ten minutes later, AA heard screaming on the lanai, a Certified Nurse Aide (CNA)11 reportedly ran outside and called for help and upon arrival AA saw R33 pulling R44's hair. CNA11 indicated in the facility's investigation report while separating the residents, R44 turned to pull R33's hair and attempted to hit R33. The residents were immediately separated. R44 had scratch marks at the back of her necks and two small open areas to the right side of her neck. R44 was crying. R33 was assessed by the nurse and found to have one scratch and two open areas to the right hand and a scratch to the left forearm. Registered Nurse (RN)3 reported R44 indicated R33 scratched her when she would not allow her to take her phone and papaya. RN3 noted there was no papaya on the table but saw R44's phone on the table. RN3 indicated R44 told her R33 took her papaya. The Clinical Coordinator was documented as interviewing R44 on 12/09/24. R44 reported she was sitting her wheelchair on the lanai when another resident tried to grab her phone and took her papaya. R44 reported telling the resident not to take her things but the resident grabbed her by the hair. R44 further stated she had to protect herself and things. R44 was seen by the psychologist for evaluation on 12/11/24. The psychologist's impression was that the altercation with other resident has resolved but there could be a flare at any time due to the resident's impulsive tendencies and extreme guarding of her possessions. The psychologist recommendations includes watching R44 close for signs of upset with other residents when in common areas, particularly when on the back lanai as this seems to be the location of most conflicts and consider placing her bed to the far wall adjacent to the windows for security/privacy. R33 was seen for evaluation by the psychologist on 12/11/24. Psychologist noted R33 lacks capacity due to dementia and tends to wander and violate privacy/property of others, thus requiring close supervision. Psychologist further states R33 requires close supervision particularly when away from main common areas, as well as, minimizing interaction with R44. On 01/27/25 at 01:09 PM interviewed R33 in her room. R33 was unable to recall any incident(s) with fell ow residents. 3) ACTS #HI00011312 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/09/24 at 04:24 AM, the facility submitted an Event Report of an allegation of resident-to-resident abuse involving R44 and R3. This is R44's third involvement in resident-to-resident abuse. R44 was identified as the alleged perpetrator. The report documents on 11/09/24 at 03:15 AM R3 was on the bedside commode yelling for assistance, the privacy curtain was closed. The RN observed R44 in her wheelchair at the foot of R3's bed. R3 reported R44 threw a plastic mouthwash bottle at her. R44 admitted to throwing the bottle at R3 as she would not shut up. R3 with no visible injury. R44 was moved to another room. The completed report submitted on 11/18/24 at 03:33 AM notes the RN found the bottle at the side of R3's bed. Subsequent progress notes indicate on 11/12/23 R44 became furious at dinner time because she was looking for banana and papaya on her dinner plate, but it was not included. Staff explained that they don't have papaya now and R44 calmed down. Approximately 20 minutes later, she was noted to be shouting and crying and when asked what was wrong, she responded she didn't know and showed a video of kids and said, send me baby. Another progress note of 11/13/24 documents R44 with behavior while in the day room. R44 was seated at the table with other residents for a resident council meeting and when another resident attempted to back up and ran into R44, they began arguing. The other resident picked up a cup of water and threw it at R44. R44 attempted to take a swing at the other resident. This was R44's second incident with another resident. R44 was assessed by the psychologist on 11/23/24. Psychologist notes R44 presenting with status post cerebrovascular accident with aphasia, right hemiplegia (a condition that causes paralysis or weakness on one side of the body), and cognitive deficits. Psychologist notes managing R44's impulsive behaviors have been challenging and further complication includes language barrier English is not her primary language. R44 was happy being placed in a private room and has been provided a cooler to keep her papaya and banana in (related to earlier incident). Psychologist further notes the room reassignment to a private and quiet location has been well received by the resident who has not had an impulsive outburst since then. The update to the care plan included intervention for an appointment with the psychologist. R3 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease with hypoxia, history of falls and bipolar disorder. A review of a significant change MDS with ARD of 12/19/24 notes R44 is cognitively intact with a BIMS score of 15. R3 was not coded for exhibiting mood or behavioral symptoms. Review of the witness statement by Registered Nurse (RN)3 notes she entered the room when she heard R3 screaming for help. Upon entering the room, R3 was on the commode with privacy curtain drawn closed. R44 was at the foot of the bed yelling at R3. R3 reported to RN3 that R44 threw a plastic mouthwash bottle at her. The progress note of 11/09/24, created on 11/11/24 notes R44 admitted to throwing the plastic mouthwash bottle at R3 but denies the bottle hit R3. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/06/25 at 11:21 AM a telephone interview was conducted with RN2. RN2 was the Charge Nurse at the time of the incident. RN2 reported by the time she went to the residents' room, R3 was already back in bed. R3 reported having pain to the left arm. RN2 stated the plastic mouthwash bottle was found on R3's bed. RN2 reported there was no history of R44 and R3 not getting along or having a history of incidents. Interview with the Administrator and Social Services regarding R44's behavior. They reported working on finding placement for this resident and had R44 sign a behavioral contract. On 01/31/25, the facility provided a copy of the Behavior Contract for R44. The contract includes the following: 1. I will notify staff immediately when I have a concern regarding another resident here at facility; 2. I will NOT display/demonstrate any physical aggression with any residents here at facility; and 3. I will refrain from ANY negative verbal comments directed at other residents here at facility. The date of signature was illegible. On 02/07/25 at 10:13 AM, the Administrator and DON confirmed the contract was signed on 01/10/25, approximately one month from R44's last incident of 12/08/24. 4) ACTS #HI00011252 On 10/05/24 at 06:50 PM, the facility submitted an Event Report of an allegation of resident-to-resident abuse between R14 and R37. A review of the Event Report and facility's staff report notes on 10/05/24 at 05:00 PM, R37 was seated in his wheelchair in the dayroom. R37 could be heard screaming out for help when R14 stood up and yelled at R37 to shut up and punched R37 in the head twice. Review of staff witness report, CNA4 indicates he was assisting another resident with his meal in the dayroom. R37 was seated at a different table with two other residents, including R14. CNA4 saw R37 was done with his meal and began making several loud vocalizations which was noted to be a frequent observed behavior of R37. R37 was attended to, not needing immediate action. A few minutes later R37 made another series of vocal outbursts. At this time, R14 reportedly began a verbal exchange with R37. R14 was witnessed to stand and strike R37 in the face. R37 was removed and returned to his room. Another witness report by RN3 notes upon completion of assisting a resident with toileting, R37 was heard to call out (repetitive behavior). RN3 told R37 that his CNA would be with him in a few moments and to hang tight for a little while which R37 responded okay. While speaking to another staff member, R37 was heard to call out and RN3 witnessed R14 stand, yell at R37 and immediately hit him. Residents were separated. R14 was admitted to the facility on [DATE]. Diagnoses include, diabetes mellitus (insulin dependent), anemia, renal insufficiency, coronary artery disease, and anemia. Review of R14's quarterly MDS with ARD of 10/14/24 indicates he is cognitively intact as he scored a 14 on the BIMS. R14 was coded with symptom of mood, having little or pleasure in doing things over the past two to six days. R14 was not coded with behavior. R14 is coded with severely impaired vision (no vision). Following the incident, R14 was assessed by the psychologist on 10/17/24. The psychologist documents R14 was frustrated and impulsively became aggressive. The psychologist surmised this was an isolated incident, R14 recognized the inappropriateness of his behavior and gave verbal assurance he will address personal issues with staff and not lay hands on another resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R14's behavioral care plan includes intervention to monitor resident for presence of agitation, frustration, physical aggression, auditory hallucinations and intervene accordingly; updates of 10/10/24 includes when agitated with loud, repetitive stimulation, do not place me near anyone who is making loud, repetitive verbal stimulation, order for psychological consult due to physical altercation with another resident. Interviewed R14 on 01/28/25 at 09:36 AM in his room. R14 was able to recall the incident. He explained the guy yells every time and this time he got disgusted and punched R37. R14 stated that he would not do that again and the staff are aware that should R37 start yelling that they would move him away. R37 further stated that he doesn't like anything about R37 and he just don't like his ass. R37 shared that he doesn't know why he doesn't like R37 as he gets along with everyone else. A review of R37's record indicates he was admitted to the facility on [DATE]. Diagnoses include non-traumatic brain dysfunction and dementia. R37 has severe cognitive impairment, scoring a four on the BIMS. He was not coded for mood or behavior. A review of the psychiatric consult dated 10/01/24 notes diagnosis of dementia with behavioral disturbance - unstable, paranoid, and anxiety of being alone. Psychiatrist documents R37 is a reliable historian, he relayed to the psychiatrist they want me to stay here and has been screaming and yelling every day for the past 8 months. R37 noted to be agitated. Follow-up with psychiatrist was done on 10/14/24. R37 is seen for medication management. R37's care plan revision includes, but not limited to, 10/23/24, please bring me back to my room after meals in order to decrease overstimulation and frustration with noise. On 02/06/25 at 11:33 AM a telephone interview was conducted with RN3. RN3 reported R14 and R37 does not have a history of not getting along, they are usually okay together. RN3 recalled R37 has behavior or yelling and screaming out, he is being seen by a psychiatrist to correct the behavior. RN3 shared R37's behavior is attention seeking so when he calls out, staff need to go over and talk to him. At the time of the incident RN3 recalled R37 calling out, R37's assigned CNA responded to him. CNA attended to resident and left. RN3 heard R37 calling again, approached him and told him to hold on, his CNA is coming back. RN3 reported CNA4 no longer works at this facility. 5) The facility's policy and procedure titled, Freedom from Abuse/Neglect/Exploitation Long Term Residents was reviewed. The purpose of the policy and procedure is to keep residents free from abuse, neglect and corporal punishment of any kind, including involuntary seclusion, by any person. The type of abuse includes resident to resident abuse which notes cognitive impairment or mental disorder does not preclude a resident from being abusive; facility will assess the resident and care plan interventions to address resident behaviors that may indicate a risk for abusive, aggressive interaction (e.g. physical, sexual or verbal aggression; taking, touching or rummaging through another's property; wandering into another's rooms/space). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The policy for training and maintaining staff's knowledge by providing education upon hire and at least annually includes but not limited to: Understanding behavioral symptoms of residents that may increase the risk of abuse and how to respond, including: i. aggressive and/or catastrophic reactions or residents; ii. Wandering or elopement-type behaviors; iii. Resistance to care; iv. Outbursts or yelling out; and v. difficulty in adjusting to new routines or staff. Also noted for preventing abuse, staff will be informed of the individual residents' care needs and behavioral symptoms, staff will identify, assess, and develop care plan interventions and monitor residents with needs and behaviors which may lead to conflict or neglect; and staff supervision will help to identify staff behaviors that may indicate potential for abuse or neglect. On 02/06/25 at 11:21 AM interviewed RN2 via telephone. Inquired what kind of training is provided regarding abuse. RN2 reported administration provides training on abuse and recently handouts were provided. Further queried what information was provided in the handouts. RN2 recalled it was a review of the process when there is suspected abuse, who to contact and to complete a report to the State Agency. Telephone interview with RN3 was done on 02/06/25 at 11:33 AM. RN3 was asked if she received training after the incident, she witnessed between R14 and R37 on 10/05/24. RN3 recalled they received training. Further queried what did she learn from the training, RN3 responded to round a little more, check on everybody, and assess before it gets worst. Further queried whether the facility provided training for providing care to residents with dementia or cognitive disabilities. RN3 recalled upon hire, training was done. Presently, RN3 stated she learns from other nurses on how to address behaviors. On 02/05/25 at 12:50 PM an interview was conducted with CNA5. Inquired what kind of training she received regarding abuse. CNA5 responded that she received in service training, which included review of the facility's policy and procedure. Further asked if the facility provided training on how to identify situations or behaviors that could lead to abuse. CNA5 responded, they were taught to remain calm and approach residents in a nice way. CNA5 is aware that if R37 becomes loud to take him back to his room. CNA5 also shared if residents become combative, they will inform the charge nurse, the resident may need medication. On 02/07/25 at 08:45 AM an interview was conducted with CNA1. CNA1 reported the facility has provided training on how to prevent abuse. CNA1 was asked what she looks for, CNA1 responded give resident water or something they want. Further asked how you ensure residents are not going to fight, CNA1 responded when they do you need to separate them. Requested documentation of the training that was provided to staff regarding abuse/neglect. The facility provided a copy of their policy and procedure, Freedom from Abuse/Neglect/Exploitation Long Term Care Residents with an attached staff sign-in form. Interview with Administrator was done on 02/07/25 at 10:28 AM. Administrator reported training is ongoing and includes review of the facility's policy and procedures. Further queried what kind of training is provided to staff to recognize behaviors that may put residents at risk for resident-to-resident abuse. Administrator explained residents' behaviors are discussed in their huddles meeting with the psychologist. Administrator was asked what if staff aren ' t' present. Administrator reported communication with the charge nurses are sent via email. Discussions are among the clinical staff.