| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 125010 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Leahi Hospital | 3675 Kilauea Avenue<br>Honolulu, HI 96816 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>40141<br><br>Based on record review, interview, and facility policy review, the facility failed to report abuse investigation results within five working days to the state survey agency for 2 (Resident #302 and Resident #28) of 6 residents reviewed for abuse.<br><br>Findings included:<br><br>A facility policy titled, Prevention of Resident Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property, dated 11/03/2021, revealed the section titled IV. Procedure included 6. Within two (2) hours, the DON [Director of Nursing]/Administrator/Nursing Supervisor on duty shall notify by email, phone or FAX [facsimile] the following State Agencies as required by State law through established procedures of the reported incident and findings within five (5) working days from the day the discovery. The policy revealed the State Agencies listed to report the incident to included Adult Protective Services (APS) and Office of Health Care Assurance (OHCA).<br><br>1. An Admission Record indicated the facility admitted Resident #302 on 05/13/2022. According to the Admission Record, the resident had a medical history that included diagnoses of Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease, and visual hallucinations.<br><br>A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/16/2023, revealed Resident #302 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff for personal hygiene and chair/bed transfers. The MDS revealed the resident required substantial/maximal assistance from staff for bed mobility.<br><br>Resident #302's care plan included a problem statement initiated on 05/30/2023 that indicated the resident used antipsychotic medications related to Parkinson's disease with psychosis and visual hallucinations. Interventions directed staff to administer psychotropic medications as ordered and to monitor for side effects and effectiveness every shift.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #302's Progress Notes, dated 11/03/2023 at 11:13 PM, revealed an entry that indicated Registered Nurse (RN) #6 had received a call from Resident #302's Power of Attorney (POA) during mealtime for RN #6 to call the spouse later from the resident's room regarding the resident's concern about day shift staff. The Progress Notes revealed RN #6 went to the resident's bedside, and Resident #302 stated that a day shift certified nurse aide (CNA) had been rough with them that afternoon. The Progress Notes revealed Resident #302 described that they were slapped on the right upper back by the shoulder blade about 15 times. The Progress Notes revealed RN #6 attempted to clarify with the resident if staff had been trying to help them to loosen their congestion, but the resident said they did not feel that way. The Progress Notes revealed Resident #302 indicated it happened around 2:00 PM but they did not report it to the day shift staff. The Progress Notes also revealed the DON was notified.<br><br>A document titled, EVENT REPORT, contained an Initial Report of alleged abuse, dated 11/03/2023 at 6:50 PM. The document revealed a notation dated 11/07/2023 at 12:36 PM that indicated the final report of the incident would be forwarded once the result of the investigation was completed. An email dated 11/07/2023 at 12:55 PM sent from the DON to the state agency also indicated the final report would follow pending an investigation.<br><br>A document titled, EVENT REPORT, contained a Completed Report, dated 01/03/2024 for the alleged abuse allegation dated 11/03/2023. An email from the DON to the state agency dated 01/03/2024 at 4:35 PM revealed the final report was sent to the state agency.<br><br>During an interview on 07/31/2024 at 11:57 AM, the DON stated for an abuse investigation there was a two-hour window to report to the State agency, then the final was due within five days. The DON said the process was for her to complete the final report and if she was not at the facility, then it was the nurse supervisor's responsibility.<br><br>During an interview on 07/31/2024 at 2:04 PM, RN #5 stated she assisted with the abuse investigation process by obtaining interviews and witness statements. RN #5 said the initial report was due to the state by two hours after the allegation. RN #5 stated the investigation started as soon as an allegation was reported. RN #5 said the DON was responsible for the final report.<br><br>During an interview on 07/31/2024 at 2:52 PM, Social Worker (SW) #22 stated the DON was responsible for the two-hour initial report and the five-day final report.<br><br>During an interview on 08/01/2024 at 8:44 AM, the DON stated the charge nurse called her that evening when Resident #302 reported that a CNA had done something to them. The DON said she went to the facility and started the investigation and completed the initial two-hour notification to the state. The DON said she was responsible for gathering the information for the investigation and the nurse manager helped with gathering statements from staff and the roommates and other residents. The DON said the CNAs were a part of a union, therefore; someone had to be brought in from the outside to investigate, and the facility had to wait for the union report. The DON stated the facility did not meet the required five-day timeframe because they were waiting for the final report from the other agencies. The DON stated her expectation was to have the five-day investigations completed and turned in timely.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 08/01/2024 at 9:26 AM, the Administrator stated that as soon as an allegation happened the facility reported to the state, then completed an investigation by the fifth day. The Administrator said if the facility had to call for an external investigation the state would be notified. The Administrator reviewed the provided documentation for Resident #302's internal investigation and stated the DON did not send the facility investigation on 11/07/2023 with the five-day notification. The Administrator stated she expected the internal investigation to be sent to the state by the fifth day, even if the facility was waiting for the external investigation.<br><br>29673<br><br>2. An Admission Record revealed the facility admitted Resident #28 on 04/07/2017. According to the Admission Record, the resident had a medical history with diagnoses that included quadriplegia, anxiety disorder, adjustment disorder with disturbance of conduct, anoxic brain damage, hemiplegia and hemiparesis (one-sided paralysis and weakness) following cerebral infarction affecting right dominant side, and dysphasia (difficulty with speech).<br><br>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2024, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that Resident #28 had no physical or verbal behaviors directed towards others.<br><br>Resident #28's care plan, included a problem statement revised on 11/09/2022 that indicated the resident had socially inappropriate behavior of talking loudly. Interventions directed staff to continue with therapeutic limits setting and include resident input to identify what could be done in place of minding other residents' business.<br><br>A Progress Note dated 09/08/2023 at 4:17 PM, by Social Worker (SW) #22 revealed SW #22 heard Resident #28 screaming at a certified nurse aide (CNA) and was told by the charge nurse that the resident was yelling profanity to the CNA. The Progress Note revealed Resident #28 was very angry and said the CNA was acting like a monkey and saying profanity to the resident. The Progress Note indicated the CNA stated the resident slammed the bathroom door and yelled expletives at the CNA. The Progress Note also indicated Registered Nurse (RN) #6 called the nursing supervisor to speak with the CNA.<br><br>During an interview on 07/30/2024 at 2:21 PM, SW #22 stated staff who heard of an allegation of abuse were to ensure the resident's safety, then notify the nurse supervisor. SW #22 stated the nurse supervisor checked on the resident and then called the Director of Nursing (DON), who was the Abuse Prohibition Coordinator. SW #22 stated the DON was responsible for reporting to state and other authorities and was responsible for the investigation.<br><br>During an interview on 07/30/2024 at 3:27 PM, RN #6 stated that an accusation of abuse from a resident required the resident and the accused to be separated and the resident assessed for safety. RN #6 said she reported to her supervisor if the supervisor was in the building; if not, she called the DON and reported the allegation. She stated the DON was responsible for reporting to authorities and investigating the incident.<br><br>During an interview on 08/01/2024 at 1:45 PM, the DON stated SW #22 submitted the initial report on 09/12/2023, and she submitted one on 09/17/2023. There was no evidence provided to indicate a five-day investigation was submitted.<br><br>(continued on next page) |

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| Leahi Hospital | 3675 Kilauea Avenue<br>Honolulu, HI 96816 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 08/01/2024 at 10:08 AM, the Administrator said the internal investigation was expected to be turned in by the fifth day. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>40141<br><br>Based on interview, record review, and facility document and policy review, the facility failed to provide evidence that an allegation of abuse was thoroughly investigated for 1 (Resident #302) of 6 residents reviewed for abuse.<br><br>Findings included:<br><br>A facility policy titled, Prevention of Resident Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property, dated 11/03/2021, revealed the section titled, I. Purpose included, B. To report and conduct a thorough investigation of all incidents within specified timelines and provide appropriate corrective actions and preventive measures. The policy also specified that when investigating allegations of abuse, investigators will, e. Conduct and document all necessary interviews with staff, witnesses, resident, and alleged perpetrator as deemed necessary.<br><br>An Admission Record indicated the facility admitted Resident #302 on 05/13/2022. According to the Admission Record, the resident had a medical history that included diagnoses of Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD), and visual hallucinations.<br><br>A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/16/2023, revealed Resident #302 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff for personal hygiene and chair/bed-to-chair transfers. The MDS revealed the resident required substantial/maximal assistance from staff for bed mobility.<br><br>Resident #302's care plan included a problem area, initiated on 05/30/2023, that indicated the resident used antipsychotic medications related to Parkinson's disease with psychosis and visual hallucinations.<br><br>Resident #302's Progress Notes revealed a communication note, dated 11/03/2023 at 11:13 PM, that indicated Registered Nurse (RN) #6 received a call from Resident #302's Power of Attorney (POA) during mealtime requesting RN #6 to call the POA later from the resident's room regarding a concern about day shift staff. The note indicated RN #6 went to the resident's bedside, and Resident #302 stated that the day shift certified nurse aide (CNA) had been rough that afternoon. The note indicated that Resident #302 described that they were slapped on their right upper back by their shoulder blade about 15 times. According to the note, the RN attempted to clarify with the resident if CNA was trying to help them loosen their congestion, and the resident said they did not feel that way. The note revealed Resident #302 reported the incident happened around 2:00 PM but they did not report it to day shift staff.<br><br>A document titled, EVENT REPORT contained an Initial Report of alleged abuse, dated 11/03/2023 at 6:50 PM. The document indicated that Resident #302 alleged that CNA #8 was rough with them. The document indicated that the resident reported that CNA #8 slapped them on their right shoulder blade area 15 times on 11/03/2023 around 2:00 PM. The document indicated the final report of the incident would be forwarded once the result of the investigation was completed.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A document titled, EVENT REPORT contained a Completed Report, dated 01/03/2024. The document indicated that, when asked, Resident #302 did not feel like the staff member was trying to help loosen their congestion. The document indicated that a complete head-to-toe assessment was completed, and no injury was noted. The document indicated that CNA #8 was suspended pending the investigation.<br><br>The facility's Daily Nursing Assignment Sheet for the day shift on 11/03/2023 revealed four CNAs (including CNA #8), RN #7, and Licensed Practical Nurse (LPN) #10 were working at the time the incident allegedly occurred.<br><br>The facility provided documentation of Employee/Resident Quality Assurance Reports and a Supervisor's Quality Assurance Report that reflected documentation of interviews and statements related to this allegation. These reports reflected that as part of the investigation into the allegation, the facility obtained information from CNA #8, RN #6, and RN #5. There was no evidence provided to indicate the facility interviewed or obtained statements from the other staff members working at the time of the alleged incident, including the remaining three CNAs, RN #7, and LPN #10.<br><br>The facility also provided documentation of two resident questionnaires, dated 11/08/2023. The facility did not provide evidence of any additional resident interviews or evidence to indicate that residents who were not interviewable were assessed for signs or symptoms of abuse.<br><br>During an interview on 07/31/2024 at 2:04 PM, RN #5 stated that the abuse investigation process included obtaining interviews and witness statements. RN #5 stated an investigation started as soon as an allegation was reported, and staff followed a checklist to not miss any steps. RN #5 stated they then gathered information from anyone who may have heard or witnessed anything. Per RN #5, residents, family, and staff members were asked to complete witness statements during the process. She stated witness statement were obtained from for Resident #302's roommate and another resident for whom the CNA had provided care that day. RN #5 read over her report and stated if she had not documented it, then there were no head-to-toe assessments performed on residents who were not interviewable. RN #5 indicated the DON was responsible for the final report.<br><br>During an interview on 08/01/2024 at 8:44 AM, the DON stated the charge nurse called her when Resident #302 reported that the CNA had done something to them. The DON indicated she went to the facility and started the investigation. The DON indicated she was responsible for gathering information for the investigation, and the nurse manager helped with gathering statements from staff, the roommates, and other residents. The DON stated they did not talk to any other residents and did not assess residents who were not interviewable for signs or symptoms of abuse. The DON indicated it was the facility policy to do those things for a thorough investigation.<br><br>During an interview on 08/01/2024 at 9:26 AM, the Administrator indicated the investigation for Resident #302 had been completed. The Administrator stated that as soon as an allegation was made, the facility reported to the state survey agency, then completed an investigation by the fifth day. The Administrator indicated a thorough investigation usually included speaking with the residents in the room of the alleged incident, if they were alert, and talking to any other residents who were in the area. The Administrator indicated they also usually talked with other staff working at the time. The Administrator stated she did not know if that occurred for this investigation. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>35314<br><br>Based on record review, interview, and facility policy review, the facility failed to refer residents with newly evident or possible serious mental disorder, intellectual disorder, or related condition, to the state-designated mental health or intellectual disability authority for review. The deficiency affected 2 (Resident #9 and Resident #39) of 2 residents reviewed for Pre-Admission Screening and Resident Review (PASARR; PASRR) services.<br><br>Findings included:<br><br>A facility policy titled, Preadmission Screening Resident Review (PASRR), dated 06/07/2018, revealed the section titled II. Policy, included, E. Social Services will be contacted for assistance with Level II evaluations and for any significant mood or behavior changes that may necessitate a Level II evaluation at any time throughout the resident's stay at [the facility]. The policy revealed the section titled, IV. Procedure, included, C. Nursing Supervisor, Unit Manager and Social Worker will review PASRR for Part C exceptions for individuals with MI [mental illness] or ID [intellectual disability]/DD [developmental disability] (i.e. [id est; that is], physician certification for less than 30 day stay that is required for condition which they were hospitalized for ); and will follow up within the accepted time frame if additional action is necessary, such as Level I re-evaluation and Level II evaluations and appropriate review by the state agencies. Further review revealed, I. When observing any significant decline in mood and behavior in a resident with SMI [serious mental illness], IDT [interdisciplinary team] will determine if a significant change minimum data set (MDS) assessment is warranted. Care plan(s) will be revised, if appropriate. If the resident does not stabilize within 21 days, Level II evaluation will be initiated and submitted to AMHD [Adult Mental Health Division] through the ePASRR [electronic PASRR] website.<br><br>1. An Admission Record indicated the facility admitted Resident #9 on 06/15/2004. According to the Admission Record, Resident #9 had a medical history that included a diagnosis of psychotic disorder (onset 10/03/2017).<br><br>Resident #9's Preadmission Screening Resident Review (PASARR) Level I Screen, dated 05/15/2004, revealed the resident did not have a mental disorder, which included psychotic disorder.<br><br>A quarterly MDS, with an Assessment Reference Date (ARD) of 07/02/2024, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #9 had an active diagnosis of psychotic disorder.<br><br>Resident #9's medical record revealed no evidence that indicated a referral was made to the appropriate state-designated authority after the resident's diagnosis of psychotic disorder.<br><br>2. An Admission Record indicated the facility admitted Resident #39 on 06/06/2017. According to the Admission Record, Resident #39 had medical history that included diagnoses of delusional disorders (onset 08/09/2018) and paranoid personality disorder (onset 08/09/2018).<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #39's Preadmission Screening Resident Review (PASARR) Level I Screen, signed by a physician on 06/06/2017, revealed the resident did not have a serious mental illness, such as psychotic disorder or delusional (paranoid) disorder.<br><br>A quarterly MDS, with an Assessment Reference Date (ARD) of 07/02/2024, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #39 had active diagnoses of psychotic disorder other than schizophrenia and paranoid personality disorder.<br><br>Resident #39's medical record revealed no evidence that indicated a referral was made to the appropriate state-designated authority after the resident's diagnosis of psychotic disorder.<br><br>During an interview on 08/01/2024 at 8:10 AM, the Director of Nursing (DON) stated the facility did not update Level I PASARRs after the residents had been admitted to the facility. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>35314<br><br>Based on interview, record review, facility document review and facility policy review, the facility failed to maintain an effective Quality Assurance and Performance Improvement (QAPI). Specifically, the facility failed to ensure corrective action was implemented and maintained to ensure sustained compliance with reporting and investigating alleged allegations of abuse. This had the potential to affect all residents that resided in the facility.<br><br>Findings included:<br><br>The Department of Health and Human Services Center for Medicare and Medicaid Services [CMS] Form CMS-2567's, dated 09/20/2021, 09/30/2022, and 09/14/2023, revealed the facility received deficiencies for F609 and F610 each year.<br><br>The facility's Quality Assurance & Performance Improvement (QAPI) Plan 2023-2024, reviewed by the facility on 07/21/2022, revealed, Decisions will be made to promote excellence in quality of care, resident choice, person directed care, and resident transitions. Focus area will include systems that affect resident and family satisfactions, quality of care, and services provided, and all areas that affect the quality of life for persons living and working in our organization. The plan also indicated, The QAPIC [Quality Assessment and Performance Improvement Committee] has the responsibility to -Review quality improvement reports on identified quality deficiencies, such as survey findings, develop appropriate plans of action to correct identified and confirmed quality concerns, implement the plans of action, monitor the effectiveness of action plans and make revisions as needed. The plan revealed Attachment G included a Performance Improvement Project (PIP) Inventory with dates of review of 11/01/2018, 02/07/2019, 03/2020, 07/2021, and 05/2023. Further review revealed the inventory did not indicate there was a PIP for the area of abuse reporting and investigating. The plan revealed Attachment H included a Performance Improvement Project (PIP) Inventory with a date of review of 05/12/2022. Further review revealed the inventory did not indicate there was a PIP for the area of abuse reporting and investigating.<br><br>During an interview on 08/01/2024 at 1:16 PM, the Director of Nursing (DON) said that all abuse allegations were discussed during the QAPI meetings, but it was not discussed whether the investigations were completed per the facility's abuse policy.<br><br>During an interview on 08/01/2024 at 2:31 PM, the Quality Assurance (QA) Coordinator stated the facility QAPI plan was not effective if the facility was being cited for the same concerns each survey. |