STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leahi Hospital	3675 Kilauea Avenue 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide the effective date of discharge in the discharge notice for one Resident (R) 98 of three residents sampled for the transfer discharge process when he was transferred to a hospital. The deficient practice has the potential misinform the representative of the Residents date of transfer. Findings include:On 06/03/25 progress notes reviewed. Resident (R) 98 was admitted to the facility on [DATE] for Physical Therapy (PT) and Occupational Therapy (OT) with a primary diagnosis of Pneumonia and Parkinson's disease. R98 was transferred to an acute care hospital three days later on 06/06/25 for respiratory failure secondary to recurrent aspiration pneumonia. On 07/24/25 reviewed the discharge and transfer notice with email documentation that was sent to the Long-Term Care Ombudsman (LTCO). The notice that was provided to the resident's representative and the LTCO did not have the date of the transfer written on the notice. On 07/25/25 at 10:30 AM, interview with the Social Services Director (SSD). Confirmed the date of the effective discharge on the transfer/ discharge notice was left blank.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interviews, and record review, the facility failed to implement the care plan for one resident (Resident (R), R38) sampled for accidents and R92, who was sampled for respiratory care. The deficient practice puts R38 at risk for falls that could result in harm if the mechanical lift is not used appropriately with two staff and puts R92 at risk for respiratory infection who already has compromised health. Cross reference to F689 1) On 07/22/25 at 08:30 AM, observed Certified Nurses Aide (CNA) 41 transferring R38 from bed to wheelchair using a mechanical lift on her own. When CNA41 was asked if the facility policy allowed her to transfer a resident using the mechanical lift by herself, CNA41 stated that she was able to if she felt capable and that R38 trusted her to do it. On 07/24/25 at 08:15 AM, interview with Head Nurse (HN) 6 and confirmed that transfers using the mechanical lift should always be completed with two staff. HN6 noted that this is for the resident's safety. HN6 also confirmed that this is noted in R38's care plan, which is accessible to all staff and should be followed as it directs the care of the resident. On 07/25/25 at 11:09 AM, record review of R38’s care plan noted in the “intervention” section for “Activities of Daily Living (ADL)-Transfers using mechanical lift with two staff assist.” Review of the facility’s “Goals and Objectives, Care Plans” policy, in the Policy Interpretation and Implementation section, it states “4. Goals and objectives are entered on the resident’s care plan so that all disciplines have access to such information…are derived from information contained in the resident’s comprehensive assessment…care plan goals and objectives are defined as the desired outcome for a specific resident problem…” 2) On 07/22/25 at 09:04 AM observed R92's oxygen (O2) concentrator in her room near the wall. On 07/24/25 reviewed R92's Electronic Health Record (EHR) which revealed she is receiving hospice services and has an order for oxygen use prn (as needed). Requested and received facility policy titled Oxygen Administration from the Director of Nursing (DON). Review of this policy found the following: Purpose. The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation . 2. Review the resident's care plan to assess for any special needs of the resident. On 07/25/25 at 10:15 AM interviewed the Director of Nursing (DON) by phone regarding R92's care plan. Inquired if DON saw any care plan for R92's respiratory care that included oxygen as an intervention. DON reviewed R92's care plan and stated she could not find anything in the care plan for oxygen use, and confirmed the resident had an order for Titrate Oxygen per nasal cannula PRN.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interviews, and record review, the facility failed to ensure that one of one resident (Resident (R), R38) sampled for accidents was free from accident hazard when staff transferred R38 using a mechanical lift with only one person assist. This deficient practice has the potential to affect all residents requiring transfers using a mechanical lift.Findings Include:On 07/22/25 at 08:30 AM, observed Certified Nurse's Aide (CNA) 41 transferring R38 from bed to wheelchair using mechanical lift on her own. When CNA41 was asked if the facility policy allowed her to transfer a resident using the mechanical lift by herself, CNA41 stated that she was able to if she felt capable and that R38 trusted her to do it. On 07/22/25 at 09:00 AM, interview with Registered Nurse (RN) 9. RN9 said that transfers using the mechanical lift should be done with two staff for safety reasons.On 07/24/25 at 08:15 AM, interview with Head Nurse (HN) 6, and confirmed that transfers using the mechanical lift should always be completed with two staff. HN6 noted that this is for resident's safety.Record review of the facility's Using a Mechanical Lifting Machine policy, revised July 2017, the General Guidelines section, notes, 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift.Review of the facility's Safe use of Mechanical Lifts training, in the Procedures and Safety section, 3. Determine if another person is needed to assist with the lift. Most lifts require two people: One person to operate the lift and one person to guide the sling. CNA41 completed the training on 04/09/22.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations and interviews the facility failed to label the oxygen tubing that was connected to the oxygen (O2) concentrator with the date if initiation for one of one resident (R) 92, sampled for respiratory care. This deficient practice put R92 at risk for infection. Findings Include: On 07/22/25 at 09:04 AM and on 07/23/2025 at 10:31 AM observed R92's oxygen (O2) concentrator in her room near the wall that had tubing connected to it which was not labeled with the date of first use. On 07/24/25 at 10:43 AM interviewed 4th floor Head Nurse (HN) 6 in R92's room. Inquired of HN6 if the O2 tubing, that was attached to the O2 concentrator, should have a date when it was initiated and she confirmed this.On 07/25/25 at 10:15 AM interviewed Director of Nursing (DON) by phone regarding R92's oxygen use. Inquired if R92 had an order for oxygen and the DON confirmed that the resident had an order for Titrate Oxygen per nasal cannula PRN . and confirmed the oxygen tubing has to be labeled with the date it was initiated (opened and attached).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review of the facility's Storage of Medication Policy, the facility failed to discard two vials of expired Influenza (flu) vaccine in Young 4's medication refrigerator. This deficient practice has the potential to affect all residents in the facility due for flu vaccination.Findings Include:On 07/24/25 at 08:15 AM, medication refrigerator was checked with Registered Nurse (RN) 9. Observed two vials of expired flu vaccine dated 06/2025 still in the refrigerator located on Young 4. RN9 said that it should have been discarded last month for safety purposes. On 07/25/25 at 08:30 AM, interview with Head Nurse (HN) 6 also noted that it should have been discarded and confirmed that discarding expired medications is for the safety of the residents and to ensure the efficacy of drugs given. Review of the facility's Storage of Medication policy dated 2007 on 07/25/25 at 11:00 AM, in the Procedures section, int notes, 14. Outdated, contaminated, discontinued or deteriorated medications.are immediately removed from stock, disposed of according to procedures for medication disposal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews and policy review, the facility failed to: 1) Discard an expired container of Lemon Juice that was stored the kitchen refrigerator and 2) Label a supplement drink stored in the resident's kitchen refrigerator with the opened-on date once it was opened. As a result of this deficiency, the facility put residents at risk for foodborne illness.Findings Include:1) During the initial tour of the kitchen, on 07/22/25 at 08:50 AM, a one-gallon container of Lemon Juice, in the refrigerator, was labeled with an expiration date of 07/19/25. The container was half full and was located on the middle shelf. Staff interview on 07/22/25 at 08:52 AM, Kitchen Manager (KM) acknowledged that the Lemon Juice container was expired and should have been discarded. KM removed the Lemon Juice container and said they would discard it immediately. Review of facility policy on Food Labeling read; Purpose, to ensure that all foods served at the facility are fresh. Outdated foods that are kept beyond their allowed shelf life are not to be used in food production or served to residents and customers. Policy, Food & Nutrition Services will monitor the shelf life of the foods purchased, prepared and served to its residents and customers. A facility Food Storage Reference Table will be maintained by Food & Nutrition that lists the dates of foods used in the facility. Foods prepared for service will be labeled with date of service… III D. Manufacturer “Used by” or Expired dates – “Use by” of Expired dates stamped or printed on the original food container by the manufacturer. Unopened products with dates that have exceeded the “Best Used” by dates will be discarded… 2) On 07/22/25 at 12:54 PM observation of the resident's refrigerator on the fourth floor contained a TWO Kal supplement drink that was opened and did not have an opened-on date. Inquired with Registered Nurse (RN) 158 if the opened TWO Kal supplement drink has to have an opened-on date. RN158 confirmed the TWO Kal supplement drink in the resident's refrigerator should have been labeled with a date when it was opened.