STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125014	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Retirement Residence	1434 Punahou Street Honolulu, HI 96822

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interviews and document and medical record review (RR), the facility failed to honor the rights of one Resident (R)1 of a sample size of three. Although R1 and a Family Member (FM)1 verbalized to nursing staff they did not want melatonin (sleep aid) administered, the staff did not honor that request, or follow up with the provider to discontinue the medication in a timely manner. As a result of this deficient practice, R1 continued to receive the melatonin, and R1 and FM1 were not included in the treatment plan after expressing concern. This could affect any resident and has the potential to be a barrier for them to obtain their highest level of psychological well being. Findings include: 1) R1 was an [AGE] year old female admitted to the facility on [DATE] for rehabilitation after small bowel resection. She had an abdominal post-op wound with secondary diagnosis that included coronary artery disease, hypertension, acute hypoxic respiratory failure, and dementia. Her records indicated she had late onset Alzheimer's disease. R1 required assistance with activities of daily living, bed mobility and transfer. On 07/31/2024, while a resident in the facility, R1 reported that a male nurse made an inappropriate comment and suggestions to her. On 08/05/2024, facility leadership met with R1's family to discuss the investigation. At that time, the Family Member (FM)1, informed the facility she was upset about two other unrelated issues, 1) R1 received melatonin, after she told the staff she not want R1 to receive the medication, and 2) R1 had a fall on a previous admission, which the FM1 felt was not acknowledged or investigated in a timely manner. 2) The Office of Healthcare Assurance received a report from Adult Protective Services regarding the alleged abuse R1 reported to the facility on [DATE]. The report included the additional concerns: - On 07/30/24, RN1 informed FM1 that she attempted to give AV (alleged victim/R1) melatonin, but AV refused; FM1 questioned if AV needs melatonin because she does not have trouble sleeping. RN1 informed FM1 that it is PROTOCOL. - FM1 informed RN1 that AV does not want melatonin and does not have trouble sleeping so she does not want melatonin given to AV. RN documented to Discontinue Melatonin on 7/30/23. (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 8/5/24, FM1 went to visit AV and observed AV appeared Drugged because she was very groggy and unable to communicate as usual; at baseline AV appears alert/oriented and able to communicate well. - FM1 asked if AV was given melatonin and AP (alleged perpetrator) confirmed that she just gave AV melatonin, FM1 informed AP that RN1 documented that it is discontinued. .- On 8/6/24, FM1 visited AP and she appeared Drugged Out and could not communicate well; AV was very drowsy and not herself. FM1 approached RN1, who checked and stated AV was given melatonin; stated she thought it was strange AV was given melatonin after it was documented on 7/30/2024 to discontinue. melatonin. - On 8/7/24, FM met with Administrator, Nursing Director, Certified Nursing Assistant Director, and Social Worker. FM1 expressed concern that Arcadia continued to administer melatonin to AV after it was documented on 7/30/24 to discontinue melatonin. 3) Review of R1's Medical Record revealed the following entries: 07/29/2024, 04:49 PM Nursing Progress Note: . Alert and Oriented x3, communicated verbally, speech is clear, is able to understand and be understood when speaking. 07/30/2024, 08:50 AM Nursing Progress Note: Received sleeping soundly. 07/30/2024, 09:02 PM Order Administration Note by Registered Nurse (RN)1: Melatonin Oral Tablet by mouth at bedtime for Insomnia Take 1.5 mg (milligram) at bedtime. Resident refused, verbalized not needed, she can sleep without sleeping aid. 07/30/2024, 01:31 AM Nursing Progress Note: .Refused melatonin, resident verbalized she can sleep without taking any sleeping aid. Husband and daughter came to visit this shift. 07/31/2024 08:44 AM Nursing Progress Note: . Per evening shift LN (licensed nurse), resident refused Melatonin t [sic] HS (hour of sleep). Order Recap Report included the order Melatonin (for sleep) Oral Tablet 3 mg. Give 0.5 tablet by mouth at bedtime for Insomnia Take 1.5 mg at bedtime. The order was started on 07/29/2024 and discontinued in the electronic medical record on 08/07/2024. Review of the Medication Administration Record revealed the nursing staff documented melatonin was administered on 07/29/2024, 07/31/2024, and 08/01/2024 through 08/06/2024. The medication was refused by R1 on 07/30/2024. The order was discontinued on 08/07/2024, after the meeting and request made again by FM1. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) On 09/05/2024 at 02:30 PM, interviewed RN1 in the conference room. She said she took care of R1 on maybe the second or third day of her admission. RN1 said she informed R1's family she had refused the melatonin because she said she didn't need it. RN1 went on to say FM1 questioned why R1 was getting melatonin because she didnt have trouble sleeping, and that she told FM1 it was routine medication. RN1 said FM1 verbalized she did not want R1 to get any more melatonin. She said she did not call the attending physician because it was off hours and not urgent, but endorsed it to the night shift, and noted it on the 24 hour report. RN1 said she expected the day shift would notify the physician and get the order to discontinue the melatonin. She said she waa back on that unit a few days later and talked to the family again. RN1 said FM1 asked if R1 had received melatonin, and she told her she had just given it to R1. She said FM1 was upset. RN1 said the melatonin was still an an active order, so assumed something had changed because she saw in the record R1 had been getting it routinely. She said at that time, FM1 asked please to just get an order to discontinue.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interviews, document and record review, the facility grievance policy did not include the necessary requirements of 1) how to file a grievance anonymously, 2) identify and communicate who the grievance official was or how to contact, 3) did not determine a reasonable timeframe that complainant could expect a completed review of the grievance, 4) that they have the right to obtain the review in writing, or 5) ensure written grievance decisions meet documentation requirements. In addition, the facility failed to identify a concern verbalized by one Resident's (R)1 Family Member (FM)1, as a grievance, did not investigate the concern timely or keep FM1 apprised of the resolution. As a result of this deficiency, FM1 did not get the results of the investigation regarding all concerns. Without an efficient process to address grievances, anyone that has a concerns, may not have their issue addressed in a timely manner. Findings include: 1) R1 was an [AGE] year old female, who had two admissions to the facility. The initial admission was on 10/25/2023, when she was admitted to the facility for rehabilitation for a left femur fracture following a car accident. She made good functional progress during her rehabilitation and was discharged home from that admission. R1 was admitted to the facility again on 07/29/2024 for rehabilitation after a surgical procedure. R1's other pertinent medical history included coronary artery disease, hypertension, acute hypoxic respiratory failure, and dementia. On 07/31/2024, R1 reported that a male nurse made an inappropriate comment and sexual suggestions to her. On 08/05/2024, facility leadership met with R1's family to discuss the investigation of this report. At that time, family member (FM)1, informed the facility she was upset about two other unrelated issues, 1) R1 received melatonin (for sleep) after FM1 told staff she and R1 did not want or need the medication, and 2) R1 had a fall during the initial admission (10/25/2023), which FM1 felt was not acknowledged or investigated by the facility. 2) Cross reference F553 Right to Participate in Planning Care. R1 and FM1 verbalized to nursing staff they did not want melatonin administered, but the staff failed to communicate this request to the provider and did not honor their choice not to receive the medication. As a result, R1 continued to receive the melatonin, until FM1 brought the issue up at a meeting with administration. 3) Reviewed the Unwitnessed Fall Report dated 11/16/2023 at 02:35 PM (incident occurred on 11/06/2023). The report included per resident's daughter's report Mom said she slid a step in the restroom but she grabbed something and stood by herself then backed to bed but has some lt (left) hip pain/sore. Wet floor was checked as being a Predisposing Environmental Factor. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reviewed the Post Fall Evaluation form V7 related to this event, completed on 11/17/2023 at 09:25 PM. The report documented there was an unwitnessed fall when R1 attempted to self toilet in her room. The Provider was notified of the fall on 11/20/2023. At that time a hip x-ray was ordered. The fall details note were 11/06/23 reported by resident's daughter, initial assessment: no pain on lt (left) hip. later reported lt hip pain, then checked x-ray, no fx (fracture), no malalignment noted. The vital signs recorded on the report were noted to have a 12/06/2023 date with time of 09:33 PM. There was no documentation in section A9 Care Planning. Reviewed the Orthopedic Surgeon progress note for 12/08/2023. The note included Tripped and fell at Arcadia, no displacement of fixation. 4) On 09/06/2024 at 12:00 PM during an interview with the Administrator in Training (ADM), inquired who the facility grievance official was, and she said it would probably be the Corporate Compliance person. Asked who kept the grievance log for the long term care facility, and she said anyone can add to it, but it is maintained on site. She went on to say she is the one who kind of oversees the grievances at the facility. Requested any documents related to the investigation of R1's fall in 2023. The ADM said the person who followed up on that was no longer at the facility, so details other than what was in the incident report were not available. Review of the grievance log revealed FM1's complaint about the melatonin was logged as a grievance, but the fall was not. When asked ADM if the verbal concern expressed by FM1 about the fall had been processed and handled as a grievance, she replied No. The ADM said both of FM1's concerns, the fall and issue of melatonin administration had been found to have been validated, but they had not communicated the findings to FM1, because the concerns had been part of the alleged sexual assault investigation, and APS (adult protective services) had not completed the investigation yet. On 09/06/2024 at 01:10 PM, interviewed the Occupational Therapist (OT) who provided care giver training to R1's family prior to discharge from her initial admission when the fall occurred. The OT, said when she was doing discharge training with the family, they verbalized R1 had a recent fall while in the facility. OT said she had not been made aware of it prior to the family mentioning it. She said she spoke with the Interim Director of Nursing about the fall at that time and that it has not been reports. On 09/06/2024 at 02:15 PM, interviewed the Director of Nursing (DON). He explained when there is a grievance/complaint, it is discussed at the daily stand up meeting and determined who the point person will be for the investigation. Inquired who maintains the grievance log, and he said The IDT (interdisciplinary team) has access, but typically it is the Social Worker. The DON said FM1's concern about the melatonin had been investigated, and they found the request to discontinue the medication was made by R1 and FM1, but that the information did not get passed on to the provider to discontinue the order. 4) Reviewed the facility policy titled Complaints Policy (ACS (Arcadia Community Services)) last reviewed 12/08/2021. The policy included: - The purpose of this policy is to protect the rights of residents, clients, members, or their legal representatives and/or interested individuals, file grievances or complaints in accordance with State and Federal laws and regulations. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Grievance: Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether or not any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care. - A complaint may be submitted orally or in writing. A written complaint must be signed by the Complainant. The COO, Program Director, Administrator, or the Member Services manager may assign the responsibility of investigating the complaint to an appropriate investigator who will complete the investigation in a timely manner.The COO, Program Director, Administrator, or the Member Services Manager or his/her designee will keep the Complainant appropriately apprised of the determination. The response may include the finding of the investigation and any corrective actions taken. If Complainant is dissatisfied with the findings, he or she may: 1. Request a meeting ., or 2. File a complaint with a governmental or advocacy agency. -If a staff member overhears or receives a complaint voiced by a resident, a resident's representative, family member, an appointed advocate, or any individual regarding: 1. Alleged abuse, neglect .or other violations of a resident's rights, the staff member must immediately report the complaint to his or her supervisor 2. Treatment, medical care, or behavior of another resident or staff member; when it involves a verbal complaint that cannot be resolved by the staff present when the complaint is made, the staff member must: a. Report the complaint by the end of his/her shift to the supervisor, . , and b. Inform the resident, a resident's representative, family member, or an appointed advocate, that their concern has been reported to management for further action and that he or she may file a written complaint without fear of reprisal in any form. -An investigation report should be filed with the COO, the Program Director, Administrator, or Member Services Manager within five (5) working days of the complaint. If the investigation cannot be completed within five (5) working days, the investigator shall provide the COO, the Program Director, Administrator, or Member Services Manager with an update on the status of the investigation and an estimate for completion of the investigation. - The COO, Program Director, Administrator, . or designee will keep the Complainant appropriately appraised of the findings or status of the investigation, as well as any corrective actions. - The COO, Program Director, . will : 1. Submit the original complaint concerning allegations of abuse, neglect, .including staff behavior;and submit the investigation, determination, actions taken, response and all other related documents to the Corporate Compliance office, or 2. File the original complaint concerning treatment, medical care, or behavior of other residents; and all related documents and actions taken into the appropriate resident's medical file, with a copy to the Corporate Compliance Officer. -The disposition of all verbal and written complaints concerning allegations of abuse, neglect harassment or other violations of resident rights should be recorded on the Complaint Log. The Corporate Compliance Officer will be responsible for recording and maintaining this log. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5) Reviewed the document titled Resident Complaint Rights & Instructions. This document included: -Verbal: Please share any complaints or concerns with any staff member. If the staff member cannot resolve your concern, you are encouraged to bring your concern to the immediate attention of the following management staff: Department Supervisor, Manager, Director; Health Care Center Charge Nurse; Social Services; Resident services Manger; Office of the COO; Corporate Compliance Officer; and President/CEO. -Written: You may file a written complaint: . On the form, please answer all applicable questions accurately, and be sure to sign and date the form; . 6) Reviewed the Arcadia Health Care Center Handbook 2024 (37 pages), which is provided to all Residents. Page 36 of the handbook included: E. Complaints. If you believe your rights have been violated, you may file a complaint with our organization, by using our confidential hotline service, the Friends Services Alliance Compliance Line at [PHONE NUMBER] or with the secretary of the Department of Health and Human Services. To file a complaint with our organization or if you have questions regarding this notice, please contact: .Corporate Compliance & Privacy Officer Arcadia Family of Companies. All complaints must be submitted in writing. There was no contact information for the secretary of the Department of Health and Human Services referenced in this handbook. There was no reference to the right to file an anonymous complaint.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interview and document review, the facility failed to report an alleged abuse to proper authorities within prescribed timeframe's. Specifically, the facility staff became aware of an alleged abuse on 07/31/2024 and did not report it to Adult Protective Services (APS) until 08/05/2024. In addition, the facility did not report the incident to the Office of Healthcare Assurance (OHCA) until 08/12/2024. Findings include: 1) The Office of Healthcare Assurance (OHCA) received a report from an outside agency (APS (Adult Protective Services)) regarding an alleged sexual abuse complaint on 08/09/2024. The report included, but not limited to: On 7/31/24 AV (alleged victim/R1) reported to a Certified Nursing Assistant (name unknown) that during the night (either on 7/30/24 or 7/31/24, AP (alleged perpetrator) came to AV's room and grabbed AV's hand then forced her to touch his penis. OCHA received a Facility Reported Incident (ACTs #11142) completed by the facility on 08/12/2024. The report was a combined initial and completed report initiated by the Administrator-in-training. 2) Reviewed the APS report titled Adult Protective Services (APS) Report Form For Vulnerable Adult Abuse dated 08/05/2024 initiated by the facility Social Worker and sent to APS. The report form included: - Directions: To report abuse, neglect, and/or exploitation of vulnerable adults: 1. As soon as possible, call the Statewide APS Reporting line: [PHONE NUMBER]. 2. Submit this form to Statewide APS Intake Unit as soon as possible, including after business hours. - Alleged Victim (AV) was [AGE] year old female resident at the facility. - Presenting concerns included: Falls, Frail/weak and Alzheimer's Disease. - Capacity: Questionable decisional capacity, alert and orients, coherent and disoriented. - Alleged Perpetrator (AP): Staff of Care Facility. - The narrative information included: Incident was reported to day CNA (certified nurse assistant) on 7/31/24. SW (Social Worker) and DCNA (Director of CNA's) went to speak with resident (R1) about incident. Resident stated that last night, she isn't sure what time, a male nurse came into her room. He was short, haole (white) and wore eyeglasses. He grabbed her hand and tried to have her touch his penis. Discussion with DON (Director of Nursing) and DCNA concluded that there was no staff (employed by facility or agency) that matched that description. Administrator reviewed camera footage of 7/31/24 to see if there was anyone matching that description who entered resident's room. [NAME] was found. SW and DCNA went to speak with resident again on 8/1/24 Resident stated that she hasn't seen the male again. (continued on next page)

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

3) Reviewed the facility Investigative Report Following Adverse Event Final/Completed Report of the alleged abuse which included timeline of investigation. The report included the following:

07/31/2024 approximately 10:00 AM: Resident shared with CNA inappropriate comment made to her.

08/01/2024 approximately 08:15 AM: Social Worker notified resident's family/POA of incident.

08/05/2024 approximately 12:30 PM: Family member called SW to see if SW had any updates .Family member inquiring about filing a report. SW to file report with APS today.

4) Reviewed the facility policy titled Residents' Rights - Freedom from Abuse, Neglect and Exploitation Policy (15C HCC, ARR HCC, HOKA) last reviewed 05/15/2024. The policy statement read The Arcadia Family of Companies (AFC) has written procedures in compliance with Federal and State regulation, regarding the rights and responsibilities of residents, including freedom from abuse. The policy included the following:

- Investigation: Complaints/Grievances: If the resident's complaint is of a serious nature, involving improper care, abuse or neglect, the Director of Nursing, Health Care Administrator or Social Worker will respond to the resident immediately. An investigation will be initiated , and a report shall be submitted to the State Agency immediately.

- Reporting/Response: The IDT (interdisciplinary team) conducts an immediate investigation of the circumstances of the incident and submits a written report of the investigation to the Administrator and CCPO. The Administrator notifies the appropriate agency of all substantial abuse, mistreatment or neglect immediately. A written report of the investigation is also done by the Administrator and submitted within 24 hours, with a final report sent within five days of completion, to required agencies, including the State Survey Agency (OCHA), the Long Term Care Ombudsman, the Office of Aging, Adult Protective Services and CCPO. Incident Reporting for Alleged Abuse inaccurately directs staff.

- The policy included an attachment titled Algorithm (flowchart) for Healthcare Reporting Process Incident Reporting for Alleged Abuse. The algorithm does not direct staff to notify APS or OHCA on an alleged sexual abuse, and directs them to notify authorities only if the abuse had been substantiated by the facility.

5) On 09/06/2024 at 10:00 AM, conducted a telephone interview the Social Worker (SW) who completed the APS report and was actively involved in the alleged sexual abuse investigation. She said it is not just the Social Worker's role to report to APS, and that anyone can do it, as they are mandatory reporters. The SW went on to say in this investigation, she was assigned to complete the APS report, and she thought the Administrator was the individual responsible to report to OHCA. The SW confirmed the timeline and that the alleged abuse was reported to facility staff on 07/31/2024 (Thursday) and R1's family was not notified until the next day. The SW said on Monday (08/05/2024) R2's family member called her for any updates, and asked about an APS report. The SW informed FM that a report had not yet been filed, but that she would do so that day. When asked why the APS report was not made sooner, she said we didn't find anything on the investigation, so didn't report it. She went on to say, That's one of the things we learned, that we have to report right away.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interviews, document review and medical record review (RR), the facility failed to promptly notify the ordering physician of significant radiology findings. One Resident's (R)2 repeat chest xray findings showed significant changes from the previous xray taken three days earlier, and were not communicated to the physician for approximately one hour after the radiologist recorded the interpretation. In addition, the facility does not have a policy/procedure or effective process in place to identify which imaging results should be called to provider. This deficient practice has the potential to affect all residents and may result in adverse outcomes. Findings include: 1) R2 was a [AGE] year old male with past pertinent medical history of hypertension, Parkinson's disease, Alzheimer's, Arteriosclerotic heart disease, diabetes, urinary retention, unsteady on feet and muscle weakness. He had advanced functional and activity of daily living dependence with on an off confusion. R2 had a fall on [DATE] while at the facility that resulted in a fractured right femur requiring surgical intervention. He was readmitted on [DATE]. Upon return R2 was diagnosed COVID positive, placed on isolation and started on antibiotic therapy. 2) RR revealed the following: Nursing Progress Notes: [DATE] at 14:43 (02:43 PM): Received resident (R2) in bed, alert, able to follow command and make need know [sic]. VS BP (blood pressure) ,d+[DATE], P (pulse) 90, R (respirations) 20, O2 sat (oxygen saturation) 91% @ 2.5 LPN (liters per minute) per NC (nasal cannula). Occasional cough noted.Continue on Ceftriazone (antibiotic) 1 gram IV (intravenous) q (every) 12 hrs (hours) x7 days ([DATE]-[DATE]) and levofloxacin (antibiotic) 500 mg (milligrams) IV QS (every day) x6 Days ([DATE]-,d+[DATE]) for sepsis, . PCP (Primary care Provider) came to visit and order Chest x-ray today for generalized infiltration heard on auscultation (when listened to lungs). [DATE] at 23:24 (11:24 PM): Resident received still on isolation. @ 1745 per CNA (Certified Nurse Assistant) on duty resident refused dinner she then gave him PM care. This writer went to check on him @ 1850 and found him pale, O2@3LPM/NC VS (vital signs) checked BP (blood pressure)-,d+[DATE], P (pulse) 63 RR (respirations) 0. Fingers still moving. No chest/abdomen rise and fall, unable to read O2 sat (oxygen saturation). Sternum rub (painful stimulus to test consciousness level) was done but unable to arouse. BP slowly dropped to Error. Charge Nurse on duty came down to check on him. Death was pronounced at 1855. Resident passed away peacefully.Called PCP @ 1903 pcp verbalized patient was okay when he did his round this morning. Read him (PCP) the result of Xray with the impression of fluid overload/pulmonary edema. Radiology Result Reports: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Arcadia Retirement Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 1434 Punahou Street Honolulu, HI 96822	

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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], a single view chest x-ray was ordered. The Radiology Results Report documented the radiologist's impression (interpretation) of significant findings was No acute cardiopulmonary disease. recommend follow-up as clinically indicated. On [DATE], a repeat chest x-ray was ordered. The radiologist's interpretation included: Comparison: [DATE]. Impression: Findings suggesting pulmonary edema/fluid overload (an urgent medical condition caused by too much fluid in the lungs, making it difficult to breath). Infection cannot be excluded. 3) On [DATE] at approximately 02:00 PM interviewed RN2 in the conference room. RN2 explained the vendor that does the x-rays for the facility sends the interpretations to the Medical Record Manager (MRM), who then will forward to the nursing staff, who would follow up as needed. She went on to say there had been a recent change, and that they are now receiving the reports to a new fax machine on the third floor. RN2 said although the MRM works until around 04:00 PM, reports are sent to her after hours. RN2 was Charge [DATE], the evening R2 expired, and she responded to the unit. She said when the RN contacted the MD about the expiration, she read the xray results to him, but R2 had already expired. RN2 said there is no phone call from the vendor if there is an interpretation that may require medical intervention, but that the nurse has to go into emails and continually look for the report. She acknowledged the process was not efficient and could cause delays in timely notification of MD of significant findings. On [DATE] at 03:15 PM, interviewed the MRM in the conference room. She said the radiology vendor fax the report to me and I shoot it out to the nurses via email. MRM explained all the nursing staff have their own email and she sends the results to all staff. She said receiving the reports and sending them on to nursing is her duty ,d+[DATE]. MRM said she gets an alert when a fax is coming in. When asked if she would be able to track what time a report was emailed to nursing, she said they are automatically deleted at a certain time. She explained she does not upload the reports in the medical record, and that is done by the day Unit Secretary, after nursing reads the reports and notifies the MD. On [DATE] at approximately 03:35 PM, during an interview with the Administrator in training, she said the facility did not have a policy for when the RN should contact a provider of Radiology findings.